

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION MDL No. 2804  
OPIATE LITIGATION

Case No. 17-md-2804

Judge Dan Aaron

This document relates to: Polster

The County of Summit, Ohio, et al.  
v. Purdue Pharma L.P., et al.  
Case No. 1:18-OP-45090 (N.D. Ohio)

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Videotaped deposition of
GEORGE STERBENZ, M.D.

October 17, 2018

9:05 a.m.

Taken at:

Akron Bar Association
57 South Broadway Street
Akron, Ohio

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11 ALSO PRESENT: Jim Torok, Videographer

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Exhibit 2	Multi-Page Document Titled "Drug Overdose Deaths, Summit County Medical Examiner 01/01/2016 to 12/31/2016," Beginning Bates Number SUMMIT_000068523 - Marked Confidential	47
Exhibit 3	E-Mail from Patrick Gillepsie to Steve Perch, dated January 31, 2017, with Attachment, Beginning Bates number SUMMIT_000118414	135
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Exhibit 5	E-Mail from Lisa Kohler to George Sterbenz and Todd Barr, dated September 12, 2017, Beginning Bates Number SUMMIT_000117014	201
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1 THE VIDEOGRAPHER: We're on the
2 record. Today's date is October 17th, 2018.
3 The time is approximately 9:05 a.m. This is the
4 videotaped deposition of Dr. Sterbenz in the
5 case of National Prescription Opiate Litigation,
6 Case Number 17-md-2804, to be heard in the
7 United States District Court, Northern District
8 of Ohio, Eastern Division.

9 Would counsel please state their
10 name for the record?

11 MS. HERMIZ: Kristen Hermiz with
12 Motley Rice on behalf of the County of Summit
13 and the City of Akron.

14 MS. KEARSE: Anne Kearse, Motley
15 Rice, County of Summit and City of Akron.

16 MS. RIVERS: Tammy Rivers, Motley
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18 Akron.

19 MS. CALZOLA-HELMICK: Gianna
20 Calzola-Helmick from Pelini, Campbell & Williams
21 on behalf of Prescription Supply, Inc.

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24 MR. ADAMS: Zach Adams from Tucker
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1 Pharmaceutical.

2 MS. RANJAN: Brandy Ranjan, Jones
3 Day, on behalf of Walmart.

4 MS. ZERRUSEN: Sandra Zerrusen from
5 Jackson Kelly on behalf of AmerisourceBergen
6 Drug Corporation.

7 MR. EMCH: Al Emch, Jackson Kelly,
8 AmerisourceBergen Drug Corporation.

9 MS. ROITMAN: Sara Roitman, on
10 behalf of Purdue Pharma.

11 MR. CHEFFO: And Mark Cheffo, on
12 behalf of Purdue Parma.

13 MR. CARTER: Ed Carter, on behalf of
14 Walmart.

15 MS. NAKAMURA: Angel Nakamura, on
16 behalf of the Endo and Par entities.

17 THE VIDEOGRAPHER: Folks on the
18 phone?

19 MS. ALLEN: This is Erin Gibson
20 Allen from Marcus & Shapira on behalf of HBC.

21 MR. DAYNO: This is Theodore Dayno
22 from Morgan Lewis on behalf of Teva.

23 MR. RAIOLA: Stephen Raiola with
24 Covington & Burling on behalf of McKesson.

25 MR. HUNTER: Tucker Hunter from

1 Kirkland & Ellis on behalf of the Allergan
2 Defendants.

3 MR. CHEFFO: Anyone else on the
4 phone?

5 THE VIDEOGRAPHER: Please swear the
6 witness.

7 GEORGE STERBENZ, M.D., of lawful age,
8 called for examination, as provided by the
9 Federal Rules of Civil Procedure, being by me
10 first duly sworn, as hereinafter certified,
11 deposed and said as follows:

12 EXAMINATION OF GEORGE STERBENZ, M.D.

13 BY MR. CHEFFO:

14 Q. Good morning, Doctor. Would you
15 please state your name for the record?

16 A. My name is Dr. George Sterbenz.

17 Q. Thank you.

18 My name is Mark Cheffo, as you just
19 heard, and I represent Purdue, and I'll be
20 asking you some questions. I may be followed by
21 some of my colleagues this afternoon.

22 You've been deposed before; is that
23 right?

24 A. Yes.

25 Q. And you have very able counsel, so

1 I'm sure that they explained some of the ground
2 rules, but let me just cover a few of them.

3 You do understand that you're under
4 oath?

5 A. I do.

6 Q. If at any time that you need a break
7 today, just let us know. Just answer the
8 question that's pending. Let us -- you know,
9 tell us and we'll be happy to take a break.
10 Okay?

11 A. Yes.

12 Q. Also, if there's anything I ask you,
13 which will likely happen from time to time, that
14 you don't exactly understand, please just let me
15 know, okay?

16 A. Yes.

17 Q. Because if you answer, I'm going to
18 assume that you understood the question; is that
19 fair?

20 A. Yes.

21 Q. Great.

22 Where are you currently employed?

23 A. I'm employed at the Summit County
24 Medical Examiner's Office located in Akron.

25 Q. And what is your position there?

1 A. I'm the chief deputy medical
2 examiner.

3 Q. And how long have you held that
4 role?

5 A. Approximately 18 years.

6 Q. Is that the title that you assumed
7 when you first joined the department?

8 A. No. I was -- I joined the medical
9 examiner's office -- so I should clarify. I
10 joined the medical examiner's office
11 approximately 18 years ago. The first year I
12 was the deputy medical examiner, and after the
13 first year, approximately, I was -- my title
14 changed to the chief deputy medical examiner.

15 Q. And that's the title that you've
16 held since that time?

17 A. That's correct.

18 Q. Would you tell us generally what
19 your job duties entail as the chief deputy
20 medical examiner?

21 A. I perform death investigations for
22 those cases which fall under the jurisdiction of
23 the Summit County Medical Examiner's Office and
24 for which I will be participating in the death
25 investigation. So I don't perform death

1 investigations on every -- or I don't
2 participate in death investigations on all of
3 the cases that the medical examiner's office
4 assumes jurisdiction of, but some of them.

5 Q. And there's another full-time
6 physician that works with you at the department;
7 is that right?

8 A. That's correct.

9 Q. And when I say "the department," is
10 that fair when we're talking about the Summit
11 County Medical Examiner's Office?

12 A. Yes.

13 Q. Okay. And that's Dr. Lisa Kohler?

14 A. That's correct.

15 Q. Is there any -- are there any other
16 doctors, physicians, who work on a regular basis
17 with you and Dr. Kohler?

18 A. Not currently.

19 Q. Was there a time when you had
20 another physician working with the both of you?

21 A. Yes.

22 Q. Who was that?

23 A. Until recently, Dr. Todd Barr was
24 the deputy medical examiner.

25 Q. And in terms of reporting, did

1 Dr. Barr report to you as the chief deputy
2 medical examiner?

3 A. Can you clarify what you mean by
4 report to me?

5 Q. Were you his supervisor or boss?

6 A. I wasn't his boss, and I wasn't his
7 direct supervisor.

8 Q. Who was his direct supervisor?

9 A. Dr. Kohler.

10 Q. And is Dr. Kohler your direct
11 supervisor?

12 A. Yes.

13 Q. As the head of the department; is
14 that right?

15 A. As the chief medical examiner for
16 Summit County, she is my immediate supervisor.

17 Q. So is it fair to say that you and
18 Dr. Barr were more coordinate colleagues than
19 one reporting to the other?

20 A. Yes.

21 Q. And did Dr. Barr essentially perform
22 the same types of duties and responsibilities
23 that you and Dr. Kohler perform?

24 A. Dr. Barr performed death
25 investigations, just as I performed death

1 investigations.

2 Q. And where is Dr. Barr now?

3 A. Cuyahoga County Medical Examiner's
4 Office.

5 Q. And do you remember when he left?

6 A. He left to join the Cuyahoga County
7 Medical Examiner's Office last spring, or this
8 past spring.

9 Q. Do you know if he made that
10 determination or was he asked to leave your
11 department?

12 A. It's my understanding it was his
13 choice.

14 Q. And how long had he been employed by
15 the Summit Medical Examiner's Office prior to
16 leaving to go to Cuyahoga?

17 A. Slightly less than a year. I don't
18 recall the exact number of months. About ten
19 months, maybe 11.

20 Q. Was he hired to be a full-time
21 employee, or was there an understanding between
22 you and the department that he would have
23 somewhat of a temporary or short-term
24 employment?

25 A. When you say "understanding" between

1 me, that I had --

2 Q. No. The department. Sometimes
3 people will say, you know, I'm going to come for
4 a year and then I'm going to transition.
5 Sometimes people will say, I'm going to -- I
6 intend to stay here for the rest of my career.
7 Do you have an understanding as to why his
8 length of time was less than a year?

9 A. I did not hire Dr. Barr. The --
10 Dr. Barr's appointment to the medical examiner's
11 office is through the executive's department,
12 and that was at the discretion of the county
13 executive and Dr. Kohler. It was my
14 understanding that Dr. Barr would be, and he
15 was, a full-time employee at the time that he
16 was employed. It's my understanding that the
17 Summit County Medical Examiner's Office, in
18 terms of our administrative staff and
19 Dr. Kohler, would have liked it if he had
20 stayed, but he chose to go to -- move to the
21 Cuyahoga County Medical Examiner's Office when a
22 forensic pathologist position became available
23 there.

24 Q. Thank you.

25 And since he's left -- since he

1 left, have you or anyone else in the department
2 been looking to replace him?

3 A. Well, I have not personally
4 performed a job search to replace the deputy
5 medical examiner, but there has been a job
6 search to replace the deputy medical examiner.

7 Q. So that's an open search to your
8 knowledge?

9 A. Well, the position is not filled,
10 and you would have to refer to Dr. Kohler and to
11 the -- to the county executive's department as
12 to the status of that position. It's my
13 understanding that there is a -- an individual
14 who will be possibly joining the office later
15 this year.

16 Q. And other than Dr. Barr, let's say
17 in the last ten years, have there been other
18 physicians who have been employed by the
19 department in a similar role doing death
20 investigations?

21 A. Yes.

22 Q. Who has that been?

23 A. Prior to Dr. Barr, Dr. Dorothy Dean
24 was the deputy medical examiner.

25 Q. And do you know her term of

1 employment, approximately?

2 A. I don't recall her exact term of
3 employment. It was years.

4 Q. And was there anyone prior to
5 Dr. Dean?

6 A. Prior to Dr. Dean, Dr. Ruiz was
7 the -- was a medical examiner in the -- in the
8 -- Summit County. I don't know what his title
9 was.

10 Q. And, again, Dr. Dean, Dr. Ruiz,
11 Dr. Barr, they all performed death
12 investigations alongside you and Dr. Kohler?

13 A. Yes.

14 Q. Is the -- in order to hold the role
15 of deputy or medical examiner, are all of these
16 folks -- do they typically have a degree in
17 forensic pathology?

18 A. It's my understanding the
19 qualifications to be a medical examiner at the
20 Summit County Medical Examiner's Office is to
21 have completed a fellowship in forensic
22 pathology.

23 There is also an expectation that if
24 that individual has not yet passed their board
25 examinations for anatomic and forensic

1 pathology, that they will successfully pass
2 those board exams also to maintain their
3 employment.

4 Q. Are you boarded in forensic
5 pathology?

6 A. Yes. I am boarded by the American
7 Board of Pathology in anatomic pathology and
8 forensic pathology.

9 Q. You -- as I understand it, you did
10 your initial education, at least your higher
11 education, in New Jersey; is that right?

12 A. That's correct.

13 Q. At Rutgers?

14 A. Yes.

15 Q. And then you worked at -- I'm sorry.
16 Then you went to Robert Wood Johnson Medical
17 School; is that right?

18 A. Yes. I attended medical school
19 at -- at the University of Medicine and
20 Dentistry of New Jersey, specifically at Robert
21 Wood Johnson Medical School.

22 Q. And would you just take us, then,
23 prior to 18 years ago, when you joined the
24 Summit County medical examiner, what was your
25 path in terms of employment?

1 A. Following my completion of medical
2 school, I performed a residency in anatomic
3 pathology at New York University Medical Center.
4 That's located in New York City.

5 After completing a residency in
6 anatomic pathology at NYU Medical Center, I
7 performed a fellowship in forensic pathology at
8 the Office of the Chief Medical Examiner for the
9 City of New York.

10 After completing my fellowship in
11 forensic pathology, I stayed at the Office of
12 the Chief Medical Examiner for the City of New
13 York as a city medical examiner. I worked in
14 the boroughs of Brooklyn and Queens.

15 And then I returned to New Jersey,
16 where I worked as a regional medical examiner at
17 the regional medical examiner's office in New
18 Jersey located in Newark, New Jersey.

19 After that, I went to California,
20 where I worked as the forensic pathologist
21 consultant to the sheriff-coroners in San Luis
22 Obispo and Santa Barbara counties.

23 And after that, I came here to Ohio,
24 where I have since been employed by the Summit
25 County Medical Examiner.

1 Q. Can you tell us the years that you
2 worked in New York and New Jersey approximately?

3 A. Can I refer to my CV so I'm correct?

4 Q. Of course.

5 MR. CHEFFO: If you have a clean
6 copy, we could actually mark it.

7 MS. HERMIZ: Sure.

8 - - - - -

9 (Thereupon, Deposition Exhibit 1,
10 Curriculum Vitae - George C.
11 Sterbenz, M.D., was marked for
12 purposes of identification.)

13 - - - - -

14 Q. Doctor, let me just show you what
15 we've marked as Exhibit 1. Would you just take
16 a look at that and let us know if that's an
17 accurate copy of your CV?

18 A. Yes.

19 Q. Great.

20 And is it relatively current?

21 A. Yes.

22 Q. And I had asked you if you would be
23 good enough to tell us when you worked in New
24 Jersey and New York. Could you do that based on
25 your CV?

1 A. Yes.

2 My fellowship in forensic pathology
3 was from 1993 to 1994. So after the fellowship,
4 I continued to work as a city medical examiner
5 in New York City, and that was between 1994 to
6 1997. I was in New Jersey for approximately one
7 year at the regional medical examiner's office,
8 and that was from 1997 to 1998.

9 Q. During those years was there an
10 incidence of crack, or what people have talked
11 about, the crack cocaine epidemic? Do you
12 recall that as a medical examiner?

13 MS. HERMIZ: Objection to form.

14 Q. You can answer, unless your counsel
15 directs you not to.

16 A. I don't have an immediate
17 recollection of the specific incidence of crack
18 cocaine in New York and New Jersey at that time.
19 There were indeed people that died from
20 cocaine-related deaths. I'm not -- I can't
21 offer testimony as to how many of those deaths
22 were specifically associated with crack cocaine.

23 Q. Do you remember dealing with cases
24 of overdoses of drugs back then?

25 A. Yes. I did deal with cases of drug

1 overdoses at that time.

2 Q. Do any types of drugs kind of stick
3 in your mind as -- as prevalent in terms of your
4 autopsies, back in the years that you just
5 talked about in New York and New Jersey?

6 A. Are you referring to illicit drugs?

7 Q. Yes.

8 A. What types of illicit drugs I recall
9 people died from in -- when I was employed in
10 New York City and New Jersey?

11 Q. With some type of frequency.

12 A. What do you mean by "some type of
13 frequency"?

14 Q. You've heard of the crack crisis or
15 crack epidemic in America? Are you familiar
16 with that?

17 MS. HERMIZ: Objection to form.

18 A. Your question seems more like a
19 statement. You're telling me that there is a
20 crack epidemic. I am aware that there is
21 illicit -- there are deaths due to illicit drug
22 abuse and crack cocaine is one of those illicit
23 drugs.

24 Q. Do you remember in the popular press
25 reading about what people were talking about as

1 a crack epidemic?

2 MS. HERMIZ: Objection to form.

3 A. So you're -- you're asking me to
4 agree that there -- with the popular press that
5 there's a crack epidemic?

6 Q. I'm asking you to just answer the
7 question, Doctor, which is, do you recall
8 being -- anything in the popular press over a
9 number of years talking about the crack
10 epidemic?

11 MS. HERMIZ: Objection to form.

12 You can answer the question if you
13 understand it.

14 A. I -- I can't say yes to the form --
15 the way you've stated the question.

16 Q. Have you ever heard the term "crack
17 epidemic" before today?

18 A. I can't say that I've heard the term
19 "crack epidemic" before today.

20 Q. Okay. When you were in medical
21 school, did you take any courses that related to
22 pharmacology or anything to do with drug
23 interactions or pharmacology or things like
24 pharmacokinetics?

25 A. You mean did I take a pharmacology

1 class as part of my medical school training?

2 Q. Yes, Doctor.

3 A. Yes.

4 Q. Are you familiar with what opioids
5 are?

6 A. Yes.

7 Q. And opioids -- is it correct that
8 opioids would include both the active ingredient
9 that's used in lawful medicines but it can also
10 be used in illicit drugs? Is that fair?

11 A. Yes.

12 Q. And are you aware that opioids have
13 the potential to cause addiction or abuse?

14 MS. HERMIZ: Objection to form.

15 A. Opioids do have the potential to
16 cause addiction and, therefore, abuse.

17 Q. And is that something that you have
18 known since medical school --

19 MS. HERMIZ: Objection to form.

20 Q. -- if not before?

21 A. Yes. I have been aware that opioids
22 can cause addiction and, therefore, abuse for
23 many years since medical school.

24 Q. And what years were you in medical
25 school?

1 A. I attended medical school between
2 19 -- 1985 to -- let me clarify. 1985 till
3 1990. I had a one-year period between my second
4 and third years of medical school where I did a
5 year of research, and that's why my medical
6 school years stretch over a five-year period.

7 Q. Okay. And the properties of
8 opioids, including their potential for addiction
9 and abuse, those were things that you learned,
10 amongst many other things, I'm sure, in medical
11 school and, in particular, with respect to your
12 studies about drug properties and pharmacology;
13 is that fair?

14 A. Yes.

15 Q. And has there ever been a time since
16 medical school that you've changed that belief;
17 in other words, have you ever -- has there ever
18 been a period of time where you thought that
19 opioids did not have a potential for abuse or
20 addiction up until today?

21 A. And can I clarify your question?

22 Q. Sure.

23 A. You're speaking in terms of opioids
24 as a general class of drugs?

25 Q. Yes.

1 A. All opioids?

2 Q. Yes.

3 A. That all opioids have the potential
4 for -- or opioids as a general class of drugs
5 have a potential for addiction and, therefore,
6 abuse?

7 Q. Yes, Doctor.

8 A. And you're asking me if I ever
9 believe that they did not --

10 Q. Right.

11 A. -- have the potential for addiction
12 and, therefore, abuse?

13 Q. Right. Since having that belief
14 that you just told us about in medical school,
15 is that a belief that you've held since that
16 time until today?

17 MS. HERMIZ: Objection to form.

18 A. When you say it's my belief, are you
19 implying that this -- that opioids having --
20 being a class of drugs that can be addictive
21 and, therefore, abused is just my personal
22 belief and not something that's established by
23 -- within the medical community scientifically?

24 Q. I think you're reading too much into
25 my question, but I'm happy to try and keep

1 clarifying it.

2 We started -- I thought you told
3 us -- we can read it back -- that you learned in
4 medical school, if not before, that opioids had
5 the potential for abuse and addiction, right?
6 Isn't that what you testified to?

7 A. That's correct.

8 Q. And I'm just trying to find out,
9 have you -- has there ever been a time where you
10 believed something other than that between
11 medical school and today?

12 A. I have never been presented with any
13 evidence that opioid drugs as a class can be --
14 are indeed non-addictive and, therefore, non --
15 do not have a potential to be abused in my years
16 of practicing medicine.

17 Q. Do you prescribe any types of
18 medicines?

19 A. No. You mean do I currently
20 actively prescribe drugs, prescription drugs?

21 Q. Yes, Doctor.

22 A. No, I do not.

23 Q. My recollection -- and I think you
24 can quote me on this one, but you'll tell me if
25 this is right -- Dr. Kohler had a similar

1 testimony, in that she doesn't prescribe -- I
2 seem to recall she gave one exception, that she
3 might prescribe certain types -- I don't know if
4 it was antibiotics, but certain types of
5 prophylactic medicines to the staff from time to
6 time if you were doing an autopsy, for example,
7 and there might be a risk to the staff of having
8 some type of negative outcome from performing
9 their jobs. Does that ring a bell to you at
10 all? Is that something that's done in the
11 medical examiner's office?

12 A. Do you mean do I prescribe
13 prophylactic drugs to staff members if they're
14 exposed to a potentially infectious disease
15 through the course of an autopsy?

16 Q. Yes.

17 A. I do not do that commonly. I let
18 Dr. Kohler do that if she feels it's necessary.
19 For the most part, staff members can receive
20 prophylactic drugs through their personal
21 physicians if it's necessary. I only have
22 recollection of needing to do that a few times
23 within the 18 years that I've been practicing in
24 instances where staff members were not able to
25 reach their personal physicians in a timely

1 fashion, generally because of the date falling
2 on a weekend or a holiday.

3 Q. So when was the last time that you
4 actually wrote a prescription?

5 A. I have not written a prescription
6 within the past year, and I can't -- I don't
7 have specific recollection of the precise date
8 where I wrote my last prescription.

9 Q. You're aware that prescription
10 opioids are still available to doctors to write
11 prescriptions, correct?

12 A. Yes.

13 Q. And you're aware that they are
14 generally prescribed for -- to manage pain; is
15 that fair?

16 A. Yes. Pain management is one of the
17 primary reasons why opioid drugs are prescribed.

18 Q. And you agree that the management of
19 chronic pain in patients is a legitimate medical
20 service, correct?

21 MS. HERMIZ: Objection to form.

22 A. The prescription of opioid drugs for
23 pain management is one of the reasons why opioid
24 drugs are prescribed to patients.

25 Q. And it's a legitimate use of opioids

1 if a doctor, in his or her medical expertise and
2 discretion, determines that a patient would
3 benefit from those medicines who is experiencing
4 chronic pain; is that right?

5 MS. HERMIZ: Same objection.

6 A. So it appears that your question is
7 referring only specifically to chronic pain
8 management.

9 Q. We can start there.

10 A. But that's what you said. You said
11 if a patient is experiencing chronic pain, then
12 it's legitimate -- then the prescription for
13 opioid drugs is a legitimate reason to be
14 prescribing those drugs.

15 Q. Yes.

16 A. I don't agree or disagree with that.

17 Q. You just don't have a view?

18 A. I don't -- I don't participate in
19 chronic pain management or prescription of
20 opioid drugs for patients with chronic pain
21 management; and chronic pain management, as it
22 developed through the 1990s and the early 2000s,
23 did not exist when I was in medical school. So
24 I don't really have an opinion for or against
25 that type of prescription practice. It didn't

1 exist at the time in the fashion as it evolved
2 into at the time that I was in medical school.

3 Q. What if I took away the word
4 "chronic"? Would pain -- would that change your
5 answer?

6 A. In what setting?

7 Q. Let's try it this way, Doctor. You
8 have -- if you see, in your profession -- your
9 professional capacity, if you see something,
10 that you think a doctor or healthcare provider
11 has done something beyond the standard of care,
12 amongst the tools or avenues available to you is
13 to actually report that doctor, correct?

14 MS. HERMIZ: Objection to form.

15 A. I'm not sure what you -- what you're
16 getting at by prescription practices beyond
17 standard of care and reporting doctors.

18 Q. If you saw something in a medical
19 record while you were performing your
20 professional duties that you thought was well
21 beyond the standard of care, do you have an
22 obligation to report that to the medical boards
23 or to your supervisors?

24 MS. HERMIZ: Objection to form.

25 The witness is here in his capacity

1 as a fact witness. He's not here about the
2 standard of care for prescription and pain
3 management.

4 Q. You can answer.

5 A. Generally speaking, the medical
6 examiner is not the doctor police.

7 Q. That's not my question, Doctor.
8 If you see something --

9 A. I didn't finish.

10 Q. Okay.

11 A. Generally speaking, the medical
12 examiner is not the doctor police. The medical
13 examiner is charged with determining cause and
14 manner of death, but the medical examiner is not
15 specifically charged with determining whether or
16 not standard of care has been followed in
17 clinical -- in a clinical setting for those
18 decedents that the medical examiner assumes
19 jurisdiction of their death investigation. So,
20 in a practical sense, the extent of the medical
21 examiner investigation is not aimed at
22 addressing the issue which you have raised,
23 which is an evaluation of -- a post-mortem
24 evaluation of ante-mortem adequacy of standard
25 of care.

1 Q. I'm going to move to strike. Let's
2 see if you can answer my question now, Doctor.

3 If you're conducting an autopsy or
4 some other function and you see something that
5 you believe is outside the standard of care, do
6 you or do you not have an obligation or a
7 responsibility to report that? It's a simple
8 question.

9 MS. HERMIZ: Objection to form.

10 A. I have never, during the course of
11 one of my death investigations, specifically
12 performed such an investigation that -- as
13 you're referring to, looking for prescription
14 practices outside the standard of care. I've
15 never had the occasion to -- to do what -- to do
16 what you are -- what you're indicating.

17 Q. So in the 18 years that you've
18 worked at the Summit County Medical Examiner's
19 Office, you have never once reported a doctor or
20 healthcare provider to any governmental or
21 medical regulatory body based on any type of
22 suspicion or conduct that you believe violated
23 the standard of care; is that fair?

24 A. Your question is making a
25 presumption that I am doing -- that I personally

1 and the medical examiner's office does an
2 investigation to determine -- to evaluate
3 standard of care, one.

4 Q. Doctor, I don't want to interrupt
5 you, but it's a yes or no question.

6 MS. HERMIZ: He's trying to answer
7 your question in the way that you've posed it.

8 MR. CHEFFO: I don't think he is.

9 Okay. That's fine.

10 A. I think it's not a yes and no
11 question. And you're making a statement.
12 You're stating that the medical examiner, during
13 the course of their investigations, has the
14 capacity to be evaluating medical or clinical
15 standard of care. The very nature of your
16 question is wrong.

17 The medical examiner office does not
18 have the capacity or the resources, in most
19 instances, to -- on a case-by-case, on a daily
20 basis to evaluate clinical standard of care. So
21 in those instances with deaths due to --
22 associated with prescription medications, I have
23 never reported a physician based upon the
24 investigation performed by the medical
25 examiner's office to a medical board for

1 deviating from standard of care.

2 Q. Have you ever reported a medical
3 doctor for any reason to a medical board?

4 A. No.

5 Q. Are you an expert in toxicology?

6 A. I am able to provide expert
7 testimony with regard to toxicology to the
8 extent that it involves my determination or my
9 need to make a determination for cause and
10 manner of death.

11 Q. So is that a yes or a no?

12 A. It's what I said it was.

13 Q. Do you hold yourself out as an
14 expert in toxicology?

15 A. I already answered that question.

16 MS. HERMIZ: Objection to form.

17 Q. I didn't understand it. Can you
18 please tell me again?

19 A. I can't be any more clear than I
20 was. I think I was very clear.

21 Q. I would disagree.

22 So you're not going to answer my
23 question?

24 MS. HERMIZ: Objection to form.

25 He's answered your question.

1 MR. CHEFFO: I don't think he did.

2 MS. HERMIZ: I disagree.

3 MR. CHEFFO: I don't want to argue
4 with you. And all you can do is just object,
5 okay, because I'm going to, right now, say that
6 we're going to reserve more time because I think
7 the witness is not being responsive and I think
8 he's intentionally trying to delay the
9 deposition by not answering. Okay. And I don't
10 say that very lightly. I don't think I've said
11 that in the last ten years, but I'm just putting
12 that on the record right now.

13 MS. HERMIZ: Okay. And I disagree.

14 MR. CHEFFO: That's fine.

15 Q. So, Doctor, are you an expert in
16 pharmacology?

17 A. I am a licensed physician and a
18 forensic -- and a physician who has been trained
19 in anatomic and forensic pathology. My -- I'm
20 not a -- specifically a pharmacologist, but I
21 can have an expert opinion to pharmacology to
22 the extent of which it involves my practice of
23 forensic pathology, just as toxicology.

24 Q. Are you an expert in pharmaceutical
25 advertising?

1 A. No.

2 Q. Are you an expert in pharmaceutical
3 marketing?

4 A. No.

5 Q. Have you ever been -- well, strike
6 that.

7 Do you know what it means, called on
8 by a sales rep? Have you heard that term?

9 A. What?

10 Q. Called on by a sales rep for a
11 pharmaceutical company, have you heard that
12 term?

13 A. No.

14 Q. I'm sorry. That was a bad question.

15 So you've never -- you cannot recall
16 ever being -- having an interaction with a
17 pharmaceutical sales rep; is that right?

18 A. That's not right.

19 Q. Okay. When was the last time that
20 you had such an interaction?

21 A. When I was in medical school.

22 Q. Okay. Other than that?

23 A. No.

24 Q. Are you required or do you attend
25 CME programs?

1 A. Yes.

2 Q. With what frequency?

3 A. I'm required to have 50 CME -- class
4 one CME credits per year.

5 Q. Do you publish in any peer-reviewed
6 literature?

7 A. I don't -- do not routinely publish.

8 Q. Have you ever published?

9 A. I have had my name on publications,
10 as indicated in my CV.

11 Q. Yeah. We weren't given a copy of
12 your CV, so I can look at that, if it's listed
13 there.

14 MS. KEARSE: Do you want us to make
15 a copy of it?

16 MR. CHEFFO: No. I can just look at
17 it.

18 Q. There's two publications here, the
19 Journal of Forensic Sciences, back in 2012, and
20 a publication in the American Journal of Medical
21 Genetics. It looks like it's accepted. Are
22 those the only two publications?

23 A. That's correct.

24 Q. May I see that?

25 Do you teach at any healthcare

1 school, medical school, nursing school,
2 dentistry?

3 A. The medical examiner -- the Summit
4 County Medical Examiner participates with
5 medical students and pathology residency
6 training through NEOUCOM and Summa.

7 - - - - -

8 (Thereupon, Deposition Exhibit 2,
9 Multi-Page Document Titled "Drug
10 Overdose Deaths, Summit County
11 Medical Examiner 01/01/2016 to
12 12/31/2016," Beginning Bates Number
13 SUMMIT_000068523 - Marked
14 Confidential, was marked for
15 purposes of identification.)

16 - - - - -

17 Q. Doctor, I've put before you what
18 we've marked as Exhibit 2. Do you see that?

19 A. Yes.

20 Q. Do you know what it is?

21 A. Well, Exhibit 2 says, "Drug Overdose
22 Deaths, Summit County Medical Examiner."

23 Q. What's the date of the document, or
24 at least the date that it looks like it might
25 have been printed out on the bottom left?

1 A. The date on the bottom left is
2 Wednesday, January 3rd, 2018.

3 Q. Have you seen this document?

4 A. No.

5 Q. Have you seen a document in the form
6 that this is presented?

7 A. Like this is a printout, you're
8 referring to?

9 Q. Yes, sir. In other words, obviously
10 you would not be able to memorize every entry on
11 a 46-page document, but is this a format of a
12 type of printout that you've seen before in your
13 professional practice?

14 A. No.

15 Q. Do you see the heading? It says,
16 "Drug Overdose Deaths, Summit County Medical
17 Examiner."

18 A. Yes.

19 Q. And it's from January 1st, 2016 to
20 December 31st, 2016. Do you see that?

21 A. Yes.

22 Q. And do you see the bottom right-hand
23 side, it says, "Summit," and then there's a
24 bunch of numbers?

25 A. Yes.

1 Q. I'll represent to you, this was
2 produced through your lawyers from the records
3 of the Summit County Medical Examiner, so these
4 were documents from the Summit County Medical
5 Examiner. That's why they're Bates stamped.

6 MS. HERMIZ: Objection to form.

7 Q. What did you do to prepare for this
8 deposition?

9 A. I met with the Summit County
10 counsel.

11 Q. And I don't want you to tell me
12 anything you talked about, but how often or how
13 many times did you meet with them and for how
14 long?

15 A. We met twice, for an hour or so each
16 time.

17 Q. When?

18 A. I don't recall the exact dates.

19 Q. Approximately?

20 A. Once a few weeks ago, and once two
21 or three months ago.

22 Q. Did you meet with anybody else in
23 connection or preparation for this deposition?

24 A. No.

25 Q. Who was there at your two meetings?

1 Was it just your two attorneys here today?

2 A. No, not both of these attorneys.

3 Q. Were there other attorneys?

4 A. There were.

5 Q. Do you remember who they were?

6 A. I have to check their cards to tell
7 you their names. There was a -- Jodi Flowers
8 was at one of the meetings, if I remember
9 correctly, along with Ms. Kearse here.

10 Q. Okay. Was anybody on the phone?

11 A. Yes.

12 Q. Who?

13 A. I don't recall.

14 Q. Were there any non-lawyers?

15 A. Not that I'm aware of.

16 Q. Did you speak with anybody other
17 than lawyers to prepare for this deposition
18 today?

19 A. No.

20 Q. Did you talk to Dr. Kohler about
21 either her deposition or your deposition?

22 A. No.

23 Q. Anyone else at the ME's office?
24 Anybody else at the ME's office?

25 A. That I what?

1 Q. Talked to.

2 A. Regarding my deposition today?

3 Q. That's the question, Doctor, yes.

4 A. No.

5 Q. Did you review any documents?

6 A. No.

7 Q. Do you have an understanding about
8 why you're being deposed today?

9 A. Yes, generally; yes.

10 Q. What is that?

11 A. I am being deposed as part of the
12 county lawsuit regarding opioid deaths for
13 your -- for the individuals that you represent.

14 Q. Do you -- other than that general
15 understanding, do you have any specific
16 understanding about anything in the lawsuit?

17 A. I have not read the lawsuit.

18 Q. If we asked you to identify all the
19 entities that were being sued, could you do
20 that?

21 A. No.

22 Q. Were you shown a copy of the
23 complaint in this case?

24 A. I think visually I saw it, saw the
25 complaint. I have not read the complaint.

1 Q. I had asked you if you looked at any
2 documents in connection with the preparation.
3 Did you?

4 A. No.

5 Q. But you did see the complaint?

6 MS. HERMIZ: Objection to form.

7 A. So I'll be more specific. I believe
8 I visually saw the complaint. I did not read
9 the complaint.

10 Q. Okay. Did you visually see any
11 other documents that you didn't read?

12 A. What type of documents?

13 Q. I don't know. I'm asking you.

14 A. What type of documents?

15 Q. You know what documents mean --

16 A. Documents other than the complaint?
17 So I have not seen this document before, and I
18 did not -- have not read that document before.
19 I believe I did visually see the complaint. I
20 have not taken the time to read the complaint.
21 And I have not been provided any other documents
22 regarding the complaint.

23 Q. Did you visually see any documents
24 other than the complaint in connection with the
25 preparation of your deposition?

1 MS. HERMIZ: Objection to form.

2 A. Not that I'm aware of.

3 Q. Would you please refer to Exhibit 2,
4 the drug overdose deaths? There's a listing
5 here of -- and if you look at the last page --
6 340 drug overdose deaths between January 1st,
7 2016 and December 31st, 2016.

8 Do you see that?

9 A. Yes. On the last page it says,
10 "Total, 340."

11 Q. Okay. And let's go back to the
12 first page.

13 Within the -- the scope of the
14 responsibilities of the medical examiner's
15 office, one of the jobs or efforts that's made
16 is to try and determine the cause of death; is
17 that right?

18 A. Yes.

19 Q. And there are various ways that
20 death can be characterized or classified; is
21 that right?

22 A. You mean the cause of death, there's
23 various ways the cause of death can be
24 classified?

25 Q. Yes, sir. Like, it could be an

1 accident, it could be a homicide, it could be
2 undetermined.

3 A. That's not cause of death.

4 Q. Okay. What is that?

5 A. Manner of death.

6 Q. Okay. So the manner of death is --
7 what are the ways that someone could be
8 classified in terms of a manner of death?

9 A. Natural, homicide, accident,
10 suicide, undetermined.

11 Q. Okay. And then how does that differ
12 from the cause of death?

13 A. Cause of death is the medical reason
14 why an individual is dead. There can be
15 thousands of different causes of death. Heart
16 attack -- a heart attack or a stroke, for
17 example, are examples of causes of death.
18 Manner of death is a medical-legal
19 classification of the death. Whereas there can
20 be thousands of different causes of death,
21 manner of death is limited to five choices:
22 Natural, homicide, suicide, accident and
23 undetermined.

24 Q. And this -- this report or document
25 was classified by drug overdose deaths. Do you

1 see that?

2 A. Yes. The heading of the document is
3 "Drug Overdose Deaths."

4 Q. And can you query your database in
5 order to identify drug overdose deaths, or do
6 you believe you would have to go through the
7 entire database to make that determination.

8 Do you understand my question?

9 A. No.

10 Q. Okay. So there's 340 entries,
11 right? We determined that, right?

12 MS. HERMIZ: Objection to form.

13 A. Well, I haven't counted the number
14 of entries, but on the last page it says,
15 "Total, 340."

16 Q. Right. And the heading says, "Drug
17 Overdose Deaths," right?

18 A. Yes, the heading does say, "Drug
19 Overdose Deaths."

20 Q. Do you know how someone would run a
21 document like this, using the databases in the
22 Summit County Medical Examiner Offices, in order
23 to produce a listing of the drug overdose deaths
24 for a particular year?

25 A. So you're asking do I know how to

1 run -- how to perform the query?

2 Q. Yes, or how it would be done.

3 A. I cannot run the query.

4 Q. Can it be done?

5 A. It can be done.

6 Q. Okay. In terms of the toxicology
7 results -- do you see that right next to "cause
8 of death"?

9 A. Yes.

10 Q. What does that represent?

11 MS. HERMIZ: Objection to form.

12 A. I didn't run this query and I did
13 not set the parameters for the query, but it is
14 a heading that says "Toxicology Results," so
15 those are the results for the toxicology screen
16 that were inputted for the decedent -- that were
17 inputted into the database for the decedent.

18 Q. So in the -- when you list
19 toxicology results, or when it's listed, would
20 that include all drugs that were found in the
21 decedent's system or is there some type of
22 cutoff that you -- or differentiation that you
23 don't list?

24 MS. HERMIZ: Objection to form.

25 A. I didn't run the query. I do not

1 enter data into the database, so when you say
2 "you" -- you were saying "you" -- I don't, so
3 "you," me, me, I do not run the queries nor do I
4 enter the data into the database, so I cannot
5 vouch for the completeness of the data in the
6 database, or I cannot offer testimony as to the
7 completeness of the data in the database.

8 Q. Let's move aside from this document.

9 When you are doing an autopsy, is
10 there typically a toxicological evaluation done?

11 A. Yeah. In the majority of instances,
12 a tox -- or a drug screen or a toxicologic
13 analysis will be performed.

14 Q. And is the idea of the tox screen to
15 identify every drug or -- strike that.

16 Is the -- is the tox screen set up
17 to identify every drug that's found in the
18 person's system no matter what level?

19 MS. HERMIZ: Objection to form.

20 A. It's my understanding that it's
21 virtually -- I don't think it's possible to
22 perform a drug screen -- I don't think it's
23 possible for any toxicology lab to perform a
24 drug screen that will detect every drug that
25 exists at all potential levels. So I think the

1 answer is, you're asking -- what you're asking
2 is impossible.

3 Q. So the answer is no?

4 A. No.

5 Q. Right.

6 What -- what drugs does the tox
7 screen look for?

8 MS. HERMIZ: Objection to form.

9 A. I am not the chemist, the
10 toxicology -- the forensic chemist for the
11 office, so if you have -- I cannot offer
12 testimony as to what drugs are specifically
13 looked for and not looked for. The toxicology
14 report does list, on the bottom of each report,
15 what is included in the routine toxicology
16 screen.

17 Q. I asked you earlier if you were an
18 expert in toxicology, and you told me you had
19 some expertise in toxicology, right, at least as
20 it relates to your job function?

21 MS. HERMIZ: Objection to form.

22 Q. Is that right?

23 A. I believe I said I can have an
24 expert opinion in toxicology to the extent that
25 it involves my need to evaluate cause and manner

1 of death.

2 Q. Okay. So that's what I want to find
3 out. When you are doing a cause and manner of
4 death, what drugs are screened for in the tox
5 studies?

6 MS. HERMIZ: Objection to form.

7 A. The toxicology report indicates
8 which classes of drugs and which types of drugs
9 are screened for. I can talk in terms of
10 generalities.

11 In general, a volatile screen is
12 performed, which will pick up drugs like alcohol
13 or ethanol and other alcohol-type drugs, related
14 drugs. For example, I know that all drugs, all
15 classes of drugs, are not routinely screened
16 for.

17 Q. So in order to determine
18 specifically which drugs, you would have to look
19 at the tox screen document, that would tell us;
20 is that right?

21 A. The tox -- the tox -- each
22 toxicology report lists which drugs and classes
23 of drugs are screened for.

24 With regard to individual deaths, if
25 there is a question with -- regarding a specific

1 decedent, one would need to look at the
2 toxicology report and refer to the individual
3 investigations to see if a specific drug of
4 concern was or was not screened for.

5 Q. So is there a standard tox screen
6 that's done for all decedents, or does that
7 change based on the circumstances of death, age,
8 sex, other factors? In other words, from time
9 to time, do you say, I'm only going to run, you
10 know, a certain number of toxicological screens,
11 or is there a kind of standard operating
12 procedure where you will just have a format and
13 it's run for everyone?

14 MS. HERMIZ: Objection to form.

15 A. I thought I answered that. The
16 toxicology report -- each toxicology report
17 lists, at the bottom of the report, the drugs
18 that are routinely screened for. That is the
19 routine screen. That is the screen that all
20 specimens will undergo. Any drug that is not
21 within the routine screen or any concern for a
22 drug that is not in the routine screen would
23 have to be screened for separately.

24 Q. And as you sit here today, could you
25 tell us the drugs that are in the routine screen

1 that you've been using for the last number of
2 years?

3 A. I can -- I can generally tell you,
4 yes. They're volatile drugs, such as alcohol;
5 common drugs of abuse, such as opiates or
6 opioids. Drugs like cocaine and methamphetamine
7 will be routinely screened for. Benzodiazepine
8 drugs will be routinely included in this screen.
9 Tricyclic antidepressants are routinely included
10 on the screen. And I don't have immediate
11 recall of all the other drug types that are
12 routinely included in the screen.

13 Q. And do you know, as to any of those,
14 whether there's a threshold, in other words,
15 above which it's the intent of the screen to
16 capture? Do you understand my question?

17 A. Are you asking is that -- do these
18 drugs have a threshold below which they are not
19 reportable?

20 Q. I think we're saying the same thing.
21 Yeah. So, in other words -- let's just use
22 alcohol, for example. Is it designed, for
23 example, to capture if someone had one beer
24 or -- in their system or the equivalent of
25 alcohol, or is it designed to capture what might

1 be, you know, something more of an alcohol abuse
2 situation?

3 A. I don't think we're talking about
4 the same thing.

5 Q. Okay.

6 A. We're not talking about the same
7 thing.

8 Q. Okay.

9 A. The screens -- as a medical
10 examiner, I have to render opinions to within a
11 reasonable degree of medical certainty. The
12 toxicology reports have to be within a
13 reasonable degree of certainty based upon the
14 scientific methodologies used. So the drugs
15 that are reported in the drug screen fall
16 within -- above a threshold that is deemed to be
17 within a reasonable degree of certainty. So
18 there needs to be a minimum amount of drug, a
19 minimum threshold of drug for those drugs to be
20 reportable.

21 So certainly there can be instances
22 where drugs, such as, say, alprazolam, for
23 example, which is a benzodiazepine drug, might
24 be present in a specimen but it doesn't reach
25 the threshold to be reportable, therefore, it

1 will not appear on the toxicology screen.

2 Q. Thank you for that.

3 So reportable, though, is that -- by
4 that does that mean that it can't be detected or
5 that it's not appropriate to report based on,
6 kind of, the analysis?

7 MS. HERMIZ: Objection to form.

8 Q. Let me see if I can just tell you
9 and see if this will help you.

10 There may be a situation, for
11 example, where you would want to know if someone
12 had heroin at all in their system, right,
13 because that would show illegal drug use; but
14 there may also be a situation where someone was
15 taking an SSRI in the normal course, and that
16 would not raise a question for you in connection
17 with your expert analysis, but to the extent it
18 looks like it may have been an overdose, you'd
19 kind of want to know kind of the threshold. So
20 what I'm trying to find out is, is it at a
21 detection level or is some judgment call made as
22 to at what level the drug is going to be
23 reportable to someone like you?

24 A. You mean at what level is the drug
25 reportable on the toxicology report?

1 Q. Yes, Doctor.

2 A. Yeah. There are threshold levels
3 by -- at which drugs are reportable on the
4 toxicology report. The specific threshold
5 levels I do not know off the top of my head.
6 But I do not do the specific chemical analysis
7 myself. That is done by the forensic chemist.
8 And I don't recall the rest of your
9 question.

10 Q. Okay. Is that -- if you wanted to
11 have -- understand with more specificity these
12 types of toxicological questions, would
13 Dr. Perch be the person that you would go to?

14 A. Yes.

15 Q. Let's go back to Exhibit 2, Doctor.
16 Let's just look at the first one for a minute.
17 It talks about, the manner of death is
18 "accident." The cause of death is "combined
19 methamphetamine and fentanyl toxicity."

20 Do you see that?

21 A. I do.

22 Q. And then there's some tox results
23 that list a number of drugs, or chemicals. Do
24 you see that?

25 A. Yes.

1 Q. Methamphetamine, amphetamine,
2 oxycodone and fentanyl, those are listed here?

3 A. Yes.

4 Q. And the cause of death is "combined
5 methamphetamine and fentanyl toxicity." Do you
6 see that?

7 A. Yes.

8 Q. There's no mention of oxycodone in
9 the cause of death. Do you see that?

10 A. Yes.

11 Q. Can you -- do you have an
12 explanation as to why that is?

13 A. No.

14 Q. Can you tell which of these you were
15 the person who performed the autopsy?

16 A. I can't tell.

17 Q. Would there be a way --

18 A. I can't tell by this document.

19 Q. There would be a way of figuring
20 out, if you wanted to know, whether this was you
21 or one of your other colleagues, right?

22 A. Yes.

23 Q. There was some testimony from
24 Dr. Kohler that, with respect to the fentanyl
25 that's listed, and I think we were talking about

1 2015 documents, it was her understanding that
2 that was largely illicit fentanyl.

3 Do you believe that when you see
4 fentanyl in the toxicology results for 2016,
5 that it is predominantly or almost exclusively
6 illicit fentanyl that's being abused?

7 MS. HERMIZ: Objection to form.

8 A. When you say "illicit fentanyl,"
9 what type of -- in what form are you referring
10 to?

11 Q. You understand that fentanyl is one
12 of those products that can be used, right, in a
13 lawful, FDA-approved medicine, right?

14 MS. HERMIZ: Objection to form.

15 A. Yes. Fentanyl is a -- can be a
16 prescription drug.

17 Q. It can also be used as a street
18 drug, so in an illicit, non-FDA approved
19 medicine that someone could abuse?

20 A. Yes.

21 Q. And when we see fentanyl -- and
22 you're free to look through this document. It's
23 listed many, many times. And based on your
24 expertise and your understanding, do you believe
25 that the fentanyl that's listed in the majority

1 of the overdose deaths in 2016 is illegal,
2 non-prescription fentanyl?

3 MS. HERMIZ: Objection to form.

4 A. So illicit -- illicit fentanyl can
5 be through a -- a duragesic patch prescribed to
6 a patient and the patch is being used
7 improperly. It's being abused or it's being
8 obtained illicitly and used. And illicit
9 fentanyl can also be non-prescription fentanyl,
10 powdered fentanyl, that is -- was outside of any
11 type of clinical use. That's simply a street
12 drug fentanyl. And I think it's safe to say
13 that the majority of the fentanyl drugs are
14 either illicit, powdered fentanyl that was --
15 never had a clinical application, or fentanyl
16 obtained through duragesic patches that were
17 either being abused or were obtained illicitly
18 and are being abused.

19 Q. Okay. And what -- what's the basis
20 for that belief?

21 A. It's -- I believe it to be true. I
22 mean, we can go back and check. We can go look
23 at all these cases and see if any of those are
24 indeed deaths due to fentanyl due to a clinical
25 practice. But I believe that these are probably

1 outside of clinical practice.

2 Q. And how would we -- if, for some
3 reason, we wanted to go back and find out if it
4 was a death associated with clinical practice,
5 how would we do that?

6 A. You'd have to review the cases that
7 were of concern.

8 Q. Understood. But can you -- a little
9 more practical. You know, one way might be to,
10 as is your practice, right, to check the OARRS
11 database? Would that be part of the process?

12 MS. HERMIZ: Objection to form.

13 A. I'm not -- so you're asking, with a
14 specific case, will an OARRS search determine if
15 fentanyl was prescribed to the patient?

16 Q. I'm going to withdraw that question
17 for right now, Doctor. Let me go back to what
18 you said.

19 You said we would have to go back
20 and look at the case file, the information.
21 What information would be in the file or
22 information available to you, if we went back
23 and looked at the medical examiner records,
24 whatever they may be, that would help us
25 determine whether someone whose tox results

1 showed fentanyl was from illicit fentanyl or
2 from clinical practice?

3 A. For example, if -- it would be
4 routine to indicate if drug -- illicit drug
5 paraphernalia was present, if illicit fentanyl
6 powder was found at the scene. So that could be
7 evaluated.

8 Q. Anything else?

9 A. We can see what -- if the individual
10 was using a fentanyl patch, we could see if --
11 if a fentanyl patch was being used.

12 Q. Do you or the investigators collect
13 medical records?

14 A. Yes.

15 Q. You could look at the medical
16 records to the extent that they were collected,
17 right?

18 A. Medical records can be requested and
19 they -- and they are -- once -- if they are
20 obtained, they will be reviewed.

21 Q. And the same would be true for
22 prescription records, right, you could try and
23 find -- get the prescription records and find
24 out if someone had a valid prescription for
25 fentanyl?

1 A. If it was pertinent to determining
2 cause and manner of death, that could be done,
3 or an attempt could be made to -- to obtain
4 prescription records.

5 Q. And you're familiar with the OARRS
6 database?

7 A. Yes.

8 Q. And, generally, what is that?

9 A. The OARRS database is a database
10 of -- it's a listing of patients and
11 prescriptions for controlled substances that's
12 entered by prescribing physicians, and it's a
13 voluntary database, as I understand it. And
14 since I do not prescribe -- prescribe controlled
15 substances, I do not actually report to the
16 OARRS database because I have nothing to report
17 because I don't prescribe controlled substances;
18 but since it's a voluntary database, it's not
19 necessarily comprehensive therefore.

20 Q. Do you ever access it in connection
21 with your work?

22 A. Yes. I can access it if I need to.

23 Q. Do you?

24 A. I do.

25 Q. Why?

1 A. I access it in those instances where
2 individuals -- generally, two reasons. To
3 review what recent narcotic prescriptions a
4 decedent might have been given; and, secondly, I
5 can access it to see if a decedent has an active
6 physician or physicians in those instances where
7 we don't have any other mechanism to evaluate
8 that.

9 Q. And why would it be important or
10 relevant to your analysis to determine what
11 recent narcotics were given?

12 A. In the course of determining cause
13 and manner of death, it's useful to know which
14 medications appearing on a drug screen represent
15 drugs being used under a legitimate prescription
16 and drugs that might be used outside of a
17 legitimate prescription.

18 Q. Why is that?

19 A. It's useful because I ultimately
20 have to determine cause and manner of death.

21 Q. And the OARRS database is one of the
22 tools available to you to determine whether
23 someone is taking a lawfully prescribed narcotic
24 or whether they are using an illicit narcotic;
25 is that right?

1 A. It's not a perfect tool, but it's
2 one resource that I can use to see if an
3 individual has a legitimate prescription for a
4 narcotic medication. The absence of being
5 listed on the OARRS database doesn't necessarily
6 mean that the drug was being used outside of a
7 legitimate prescription because it's a voluntary
8 reporting system.

9 Q. So is it fair to say it's not
10 perfect, but it's not useless either, right?

11 A. That's correct.

12 Q. And, in fact, it's something that
13 you do rely on in your daily work, but you
14 understand that it has some limitations?

15 A. Yes. I use the OARRS to assist me
16 in my -- in my death investigation to help
17 determine -- or make a determination ultimately
18 for cause and manner of death.

19 Q. So if you wanted to find out if
20 anyone who -- their cause of death -- let me
21 strike that. Let's use a real example.

22 The second listing here -- this is
23 the 55235; do you see that, Doctor?

24 A. Yes.

25 Q. And this is a 40-year-old woman, and

1 it says fentanyl toxicity is the cause of death,
2 right?

3 A. Yes.

4 Q. And there's a listing of fentanyl,
5 and it has an amount that presumably was
6 detected in the blood?

7 A. Yes.

8 Q. And the only one in this one listed
9 is fentanyl and the cause of death is fentanyl
10 toxicity?

11 A. Yes.

12 Q. Just a quick question before we get
13 to my other question, Doctor.

14 Are you aware of what the threshold
15 is for fentanyl, for example, that is deadly?

16 A. In what setting?

17 Q. Death.

18 A. I don't think you know what you're
19 asking.

20 Q. Then all you need to do is just ask
21 me to clarify it.

22 This has 11.8, and then above it, it
23 says 14.2. Do you see that?

24 A. Yes.

25 Q. I'm just trying to find out --

1 A. When you say "above it," you mean
2 the other decedent?

3 Q. The entry above it. I'm just trying
4 to find out, if you know, if that said 2, would
5 that tox result be something that would lead you
6 to say it was the cause of death because it
7 could be the cause of death, or does it have to
8 be 10? I'm just trying to find out if there's a
9 threshold, that, if that was the only thing in
10 the system, would cause you to determine that
11 fentanyl was the cause of death.

12 A. The post-mortem drug screen is not
13 the only consideration for determining cause and
14 manner of death in an individual that's
15 ultimately certified as a drug overdose.
16 Generally, a complete autopsy examination will
17 be performed, and it's a consideration of the
18 investigation, scene investigation, medical
19 history if available, and the physical findings
20 at the time of the autopsy that will ultimately
21 combine and be considered for determination for
22 cause and manner of death.

23 And an individual could have a
24 fentanyl level of 11.8 nanograms per milliliter,
25 like the second decedent in this list, and they

1 might -- their toxicology report alone is not,
2 you know -- you know, the -- you know,
3 necessitate a determination for -- that this
4 person is a drug overdose. If this person had a
5 bullet hole through their head, that would be a
6 very important consideration also.

7 Q. I agree, and I wasn't trying to
8 imply that. I'm just really trying to just
9 understand if there are any, essentially, kind
10 of rules of the road, right; if it's above a
11 certain amount, it can be deemed legitimately to
12 be caused by a fentanyl-related death or, if
13 it's below, it's at such a low level, that it
14 would be unrealistic. And I'm just trying to
15 find out if there's any guideposts that you use.

16 A. There is no safe amount, or there is
17 no recognized safe amount of illicit drug or --
18 or there is no recognized safe amount of drug
19 abuse, whether it's abuse of illicit street
20 drugs or abuse of what would be prescription
21 drugs but are illicitly obtained on the street,
22 or prescription drugs that are being used
23 outside the scope of the directions of the
24 prescription. So there is no recognized safe
25 amount of drug abuse.

1 Q. I think I understand. Thank you.

2 So, just hypothetically, if this had
3 said fentanyl .8, it's possible that that could
4 still be the cause of death because there's no
5 recognized minimum threshold; is that fair?

6 A. It -- a lower level of fentanyl
7 identified on the post-mortem drug screen for
8 individual case number 55235 would not negate
9 the possibility of certifying that individual as
10 a drug overdose because, one, there is no
11 recognized safe amount of drug abuse; two, the
12 post-mortem drug screen is simply a snapshot in
13 time. It is not a representation of the peak
14 intoxicating concentration for that individual.
15 That is -- the peak intoxicating concentration
16 is essentially unknown, but the post-mortem drug
17 screen lets us confirm that the individual was
18 indeed using that drug, and then the complete
19 death investigation can give an indication if it
20 was being used abusively and in what way, and
21 are there any other physical findings or medical
22 issues that need to be considered concurrently
23 in determining the potential lethality of the
24 presumed drug, you know -- the -- if we're
25 talking in terms of drug abuse, presumed drug

1 abuse in any given individual.

2 Q. Let's look at 55235 again for a
3 minute. If it was important for you to know
4 whether this individual ever received a
5 prescription opioid prior to ingesting this
6 fentanyl, how would you do that?

7 A. I don't need to know if a decedent
8 has ever received a specific drug legitimately.
9 I just need to know, did they have a legitimate
10 active prescription for a drug that's being
11 evaluated at the time of determining cause and
12 manner of death.

13 Q. Well, let's just -- let's assume it
14 was for a homicide or some other investigation.
15 Let's say that was a question that was asked of
16 you by your supervisor, you know, I'd like to
17 find out if any -- if this particular person had
18 a lawful prescription. How would you do that?

19 A. You mean a current prescription?

20 Q. Or a prior prescription.

21 MS. HERMIZ: Objection to form.

22 A. I don't know if I can, with absolute
23 certainty, go back through any decedent's entire
24 medical history to find out if they've ever had
25 a -- a legitimate prescription for a drug. I

1 can, for example, make some attempts to see if
2 an individual has a current prescription for
3 a -- for a drug. If we know who their physician
4 is, we can ask for their active prescription
5 medications. If there's a concern for a
6 controlled substance, I can look that individual
7 up on OARRS to see if there is a recent
8 prescription, recognizing that the absence of
9 that recent -- inclusion in OARRS doesn't
10 necessarily exclude a -- the potential for a
11 legitimate prescription. We can also interview
12 family members to see what prescriptions that
13 they might have, and we can try to retrieve
14 prescription medication bottles if there's a
15 residence that's the scene of the death.

16 Q. Understand, I'm not talking about
17 absolute certainty or precision, but if -- if it
18 was important to you, for your investigation, to
19 find out, not just recent but prior prescription
20 history -- I think we talked about a few of
21 them -- one is you could look at the OARRS
22 database, right, and that would tell you, at
23 least as far as the information that's posted in
24 that database, right?

25 MS. HERMIZ: Objection to form.

1 A. I'm going to review the OARRS
2 database to the extent that it's important to me
3 for determining cause and manner of death, and I
4 don't ever recall reviewing the OARRS database
5 as a tool for determining if a decedent has ever
6 been prescribed a medication. The OARRS
7 database generally has a default for the time
8 period that it will list, unless one manually
9 changes the default, and it's -- the majority of
10 the OARRS searches are going to be back when --
11 12 months prior to the date of the search.

12 Currently, I know the default has
13 been set back two years.

14 Q. And, Doctor, for purposes of these
15 questions, I'm not -- and I understand it's your
16 distinction, it's not something you've done, but
17 these are questions, you know, if you had to in
18 a circumstance, right, or wanted to, how would
19 you do it. So for the next few questions, let's
20 just assume -- I'm just asking you as an expert,
21 and understanding if there some was medical
22 reason or investigatory reason that you needed
23 to do it. So that's what I'm going to be asking
24 you.

25 Do you know how far back you could

1 go back in terms of looking at OARRS, if you
2 wanted to manually adjust it?

3 A. It's my recollection that I can go
4 back, I think, five years.

5 Q. Okay. If you wanted to, you could
6 go back and certainly look at the records in the
7 file, whatever was there, whatever medical
8 records, right?

9 A. You mean primary care physician
10 records?

11 Q. Sure. Whatever was in the file.

12 A. Right. That's going to vary
13 depending upon the individual physician's office
14 as to what -- their individual recordkeeping.

15 Q. I understand, but you could start
16 with them, right?

17 A. To find out if -- so I have to
18 clarify. It seems you're asking me if I wanted
19 to do a -- an investigation as to if an
20 individual has ever been prescribed a
21 medication.

22 Q. I'm trying to find out what tools
23 are available to you as a person who's worked at
24 the department for 18 years. So let me see if I
25 can give you a hypothetical, and you may quibble

1 with the terms, but it's just an example, okay?

2 There was -- let's say a person
3 had -- had a tox study that showed fentanyl,
4 okay, and they had illicit drug material
5 available to them, and -- but there was a
6 question about whether that was actually an
7 overdose or suicide or homicide, right, whether
8 the person -- there was some suspicion, for
9 example, that someone may have actually tried to
10 set that up and make it look like a homicide,
11 right, and you or your investigator had some
12 suspicion. Some of the factors that you might
13 look for are whether this person ever had a
14 history of drug abuse, whether they reported
15 that, whether their family did, whether they
16 took other medicines, right? In a homicide
17 situation, wouldn't that be some of the things
18 that you would try to validate whether or not it
19 was likely an overdose or whether there was some
20 other foul play?

21 MS. HERMIZ: Form.

22 A. Are you talking about poisoning?

23 Q. I'm talking about homicide.

24 A. In what -- I don't understand -- I
25 don't understand. I don't understand your

1 hypothetical.

2 Q. I'm going to strike. If we're going
3 to quibble about -- I'm talking about someone
4 who is set up for murder, okay. You don't
5 understand my question?

6 A. You mean like a gunshot wound or a
7 stab wound case?

8 Q. No. Someone who made it look like
9 someone had overdosed on an illicit drug.

10 A. But they didn't?

11 Q. That's what you would find out,
12 isn't it? Wouldn't that be part of your job, to
13 determine whether it was a homicide or an
14 overdose?

15 A. Okay. Let me clarify your
16 hypothetical. So are you saying that if that
17 individual was given a drug and, therefore, it's
18 a homicide versus they personally took the drug?
19 Is that what you're saying?

20 Q. A homicide is someone else trying to
21 kill them, right?

22 A. A homicide is generally, by
23 convention, defined as death at the hands of
24 another.

25 Q. Okay.

1 A. With individuals using drugs
2 recreationally, drug abuse, the -- "by
3 convention," the certification or the
4 classification for their manner of death is
5 accident. That's not to say that the person
6 who's providing them the drug didn't commit a
7 crime potentially, but the individual using the
8 drug recreationally will be classified as an
9 accident.

10 Q. My question is, if someone
11 intentionally tried to kill someone and make it
12 look like that person overdosed. That's my
13 question. That's the scenario I'm positing.

14 MS. HERMIZ: Objection to form.

15 A. So you're talking in terms of
16 poisoning?

17 Q. Yes, with fentanyl, for example.
18 And -- do you understand it?

19 A. Is there more to the --

20 Q. There is, but I don't know if you
21 understand that or not.

22 A. So you're proposing a hypothetical
23 where an individual is poisoned. They don't
24 realize they're taking a drug, but they're being
25 slipped a drug, so to speak.

1 Q. Right. It looks on a tox study that
2 they have overdosed by fentanyl. Okay?

3 A. That they have -- so on their drug
4 screen there's a large amount of fentanyl?

5 Q. Right.

6 My question is, if there's a
7 question about whether that was a homicide,
8 there would be a number of questions that you,
9 and probably others, would need to answer,
10 correct?

11 A. I would have to establish to a
12 reasonable degree of certainty that that
13 individual was poisoned to -- you know, was --
14 that that individual was poisoned, that they
15 were not -- that is not a recreational drug use
16 then.

17 Q. Understood.

18 A. And I would do that in conjunction
19 with a law enforcement agency at that point.

20 Q. Okay. Would you -- would you look
21 at their prior medical history, the decedent's?

22 A. I mean, the kind of -- this scenario
23 that you're proposing is not that usual, and at
24 that point I would -- if I had a serious concern
25 that there is a homicidal poisoning, I would

1 indeed elicit the appropriate local law
2 enforcement agency where that death occurred
3 and, in those circumstances, I would probably
4 have the law enforcement agency obtain medical
5 records.

6 Q. Can you tell from looking at any of
7 these overdoses and -- on this page, on this
8 document, whether or not they had a lawful
9 prescription for an opioid medicine?

10 A. I -- I can't tell by looking at this
11 printout alone, no.

12 Q. Okay. Now, let's go through this a
13 bit more. Look at the second page on 55260,
14 please. I'm calling out this one because I
15 think this is the next entry that has oxycodone
16 listed as part of the tox studies, amongst
17 others. Do you see that?

18 A. Yes, case number 55260.

19 Q. And it has fentanyl, oxycodone,
20 benzo -- how do you pronounce that, Doctor?

21 A. Benzoylecgonine.

22 Q. -- benzoylecgonine and Tramadol.
23 The cause of death is fentanyl and cocaine
24 toxicity overdose. Do you see that?

25 A. Yes.

1 Q. Do you know why fentanyl and cocaine
2 are specifically listed and the others are not?

3 A. No. I don't have a recollection if
4 case number 55260 was my personal death
5 investigation or not.

6 Q. Is there anything about the
7 information that's listed here that would
8 explain why oxycodone was not listed as the
9 cause of death?

10 A. No.

11 Q. And then look at 55281 on the next
12 page. Do you see that? It's 1-23-2016.

13 A. Yes.

14 Q. And oxycodone is, along with
15 morphine and alazopram, listed as the tox
16 results. Do you see that?

17 A. Yes.

18 Q. And, in this one, it's acute mixed
19 heroin, alazopram and oxycodone toxicity listed
20 as the cause of death. Do you see that?

21 A. Yes.

22 Q. And in this situation, the amount
23 found is 54 nanograms per milliliter, and in
24 55260 it's 143 nanograms per milliliter. Do you
25 see that?

1 A. Yes.

2 Q. Do you have an explanation as to why
3 oxycodone is listed as the cause of death in
4 55281, where the amount is about one third of
5 the amount listed in 55260, but it's not listed
6 in 55260?

7 MS. HERMIZ: Objection to form.

8 A. Let me clarify. You're asking if
9 just looking at this printout --

10 Q. Yes.

11 A. -- can I explain why the cause of
12 death excluded oxycodone for case number 55260,
13 whereas the cause of death included oxycodone
14 for case number 55281?

15 Q. That's correct.

16 A. I can't.

17 Q. Okay. Would you look at 55336?
18 It's a 2-19-2016 entry.

19 A. Yes.

20 Q. Do you see the oxycodone listed in
21 the tox results is 755 nanograms per milliliter?

22 A. Yes.

23 Q. And the cause of death is acute
24 oxycodone toxicity?

25 A. Yes.

1 Q. It's listed as an accident. Do you
2 see that?

3 A. Yes.

4 Q. Is there anything about the amount
5 that's found in the tox studies that would cause
6 suspicion as to whether this was a suicide?

7 MS. HERMIZ: Objection to form.

8 A. I can't answer that concern simply
9 looking at the data that's listed here.

10 Q. Well, just looking at the number,
11 does someone having 755 nanograms per milliliter
12 in their system, does that -- as a person who's
13 been doing this for 30 years, does that raise
14 any questions to you as to whether it's a
15 potential suicide?

16 A. It could present a concern.

17 Q. Why?

18 A. The level is higher than in
19 individuals that are using the oxycodone within
20 a prescription, legitimate prescription, and
21 higher than in some individuals using it
22 abusively, so it could present a concern.

23 Q. And am I correct that, unless
24 there's some type of definitive evidence, like a
25 note, that the medical examiner's policy is to

1 list it as an accident, not a suicide?

2 MS. HERMIZ: Objection to form.

3 A. Suicide is a classification of death
4 by an intentional self-destructive act. Like
5 all certifications, it has to be within a
6 reasonable degree of certainty. You said
7 "definitive." I will point out that no
8 certification has to be within absolute
9 certainty. Absolute certainty is an
10 impossibility, but to a reasonable degree of
11 certainty. And I'll also point out that the
12 presence or -- of a note, though that might add
13 to a reasonable degree of certainty, it might
14 not. On the other hand, the absence of a note
15 does not exclude a reasonable degree of
16 certainty for a potential suicide death either.

17 Q. So then how would you determine to a
18 reasonable degree of certainty that this is an
19 accident as opposed to a suicide?

20 MS. HERMIZ: Objection to form.

21 A. One would have to look at that
22 individual case.

23 Q. Is there a default, as a general
24 matter -- I believe as Dr. Kohler testified --
25 that, unless there's a high degree of confidence

1 that it's a suicide, it's listed as an accident?

2 MS. HERMIZ: Objection to form.

3 A. The determination for classification
4 of manner of death needs, once again, to be
5 within a reasonable degree of certainty.

6 There are probably instances where
7 certain manner of deaths are underrepresented
8 and some manner of deaths are overrepresented,
9 so, therefore, individuals that are chronic drug
10 abusers are likely to be classified as
11 accidental deaths if their investigation
12 supports that they died due to an acute drug
13 toxicity even in those instances where it's
14 possible that they had some suicidal intent at
15 the time they abused the drug, if there is
16 insufficient investigative evidence to indicate
17 that there was suicidal intent. So, therefore,
18 if a chronic drug abuser doesn't use -- uses a
19 drug with dis -- with disregard for their health
20 and some intent to cause self-harm, there --
21 they're very likely going to be classified as an
22 accident.

23 But, on the other hand, you can
24 argue that that behavior that they've been
25 practicing for a period of time is chronic,

1 self-destructive behavior and that, for purposes
2 of statistics for local, state and federal
3 statistics, they are indeed better classified as
4 accidental deaths.

5 So, you know, if that individual,
6 you know -- well -- so, yes, I -- people who are
7 chronic drug abusers have the potential for
8 being overrepresented as accidental deaths as
9 opposed to suicidal -- suicide deaths, but I
10 think you can argue, on the other hand, that
11 maybe that's better -- where they're better
12 classified in the absence of documentation of
13 explicit suicidal ideation.

14 Q. So if there's someone -- let's go
15 off opioids for a minute. If there's a very
16 large and un, kind of, clinically appropriate
17 amount of benzodiazepine in someone's tox study,
18 is an initial thought that that's a suicide?

19 A. Well, initially we're not going to
20 know what their blood level of drug is going to
21 be. Initially there's going to be a scene
22 investigation.

23 Q. I'm talking about initially when you
24 get the tox study.

25 A. When I get the tox study, I'm going

1 to be considering the drug -- the toxicology
2 results in connection with the entirety, the
3 totality of the investigation. A strikingly
4 large drug -- post-mortem drug level will
5 present a concern certainly for an intentional,
6 self-destructive act that needs to be
7 considered.

8 Q. So does this -- does this amount, on
9 its face, raise that concern in case 55336?

10 MS. HERMIZ: Objection to form.

11 A. I don't know enough about the
12 entirety of the case to answer that yes or no.
13 One would need to look at the entirety of the
14 case.

15 Q. So the answer is no, just by looking
16 at the tox study showing oxycodone, 755
17 nanograms per milliliter, you can't -- that
18 would not raise a significant concern in your
19 mind as to whether that was a suicide? Is that
20 what you're saying?

21 A. I'm saying you cannot certify to a
22 reasonable degree of certainty cause and --

23 Q. That's not what I asked.

24 A. -- manner of death based upon the
25 drug screen, and the best you can say is the

1 drug -- the toxicology, a strikingly large
2 amount of drug on a post-mortem drug screen can
3 present a concern that needs to be considered.
4 So I think this would present -- in case number
5 55336, that drug level can present a concern for
6 an intentional, self-destructive act that needs
7 to be considered in the course of determining
8 cause and manner of death.

9 Q. So is that strikingly large in your
10 professional judgment?

11 A. It is a large amount of oxycodone.

12 Q. It's strikingly large, isn't it?

13 MS. HERMIZ: Objection to form.

14 A. It is a -- it's a large amount of
15 oxycodone.

16 Q. Okay. You used the word "strikingly
17 large." I'm trying to find out what that means.
18 Is that strikingly large?

19 MS. HERMIZ: Objection to form.

20 A. I -- I don't know enough about this
21 specific individual based -- this is just not
22 enough information.

23 Q. What is a strikingly large amount of
24 oxycodone in someone's tox study?

25 MS. HERMIZ: Objection to form.

1 A. I can't specifically quantitate that
2 at this moment.

3 THE VIDEOGRAPHER: Is this a good
4 time to change the videotape?

5 MR. CHEFFO: Sure. Why don't we
6 take a five-minute break.

7 THE VIDEOGRAPHER: Off the record,
8 10:58.

9 (Recess had.)

10 THE VIDEOGRAPHER: Back on the
11 record, 11:16.

12 BY MR. CHEFFO:

13 Q. Doctor, we're back on the record.
14 You mentioned Dr. Dean earlier
15 today, I think?

16 A. Yes.

17 Q. Do you know where Dr. Dean is
18 located now?

19 A. I believe she's at the Hamilton
20 County Coroner's Office.

21 Q. Okay. In order to determine a cause
22 of death and a manner of death, to the extent
23 that it's the same, is the standard reasonable
24 degree of medical certainty?

25 MS. HERMIZ: Objection to form.

1 A. The -- the determination of cause
2 and manner of death needs to be made to within a
3 reasonable degree of medical certainty.

4 Q. So the answer is yes?

5 A. Well, you said the cause and manner
6 of death, to the extent that they're the same,
7 but I'm not sure what you meant.

8 Q. Same standard.

9 A. Oh, same standard. Yes, the
10 standard for cause and manner of death are both
11 reasonable degree of medical certainty.

12 Q. And if you can't come to a
13 reasonable degree of medical certainty, is that
14 when the designation of undetermined is used?

15 A. Yes.

16 Q. In looking at any individual drug
17 overdose case in Exhibit 2, just as an example,
18 am I correct that we could not determine whether
19 that person was ever lawfully prescribed an
20 opioid unless we went back and looked at the
21 file and did some additional digging?

22 A. One, you cannot determine if any
23 decedent had a legitimate prescription based
24 upon this database as I'm reviewing it right
25 now; and, yes, you would have to do additional

1 digging or effort to determine if an individual
2 had a legitimate prescription. Reviewing the
3 file would be a start, the case file.

4 Q. And you would agree with me that
5 such an analysis or evaluation would necessarily
6 have to be done on a case-by-case basis?

7 A. Yes.

8 Q. You're not aware of any aggregate
9 model that would tell us which of these people
10 started on a prescription, are you?

11 A. I don't do the database query -- or
12 I don't perform the database queries for the
13 medical examiner's office. I'm not aware of a
14 parameter that would -- I'm not aware of a
15 parameter that's routinely inputted into the
16 database that would indicate who might have been
17 the decedent's prescribing physicians, for
18 example. You would have to refer to those
19 individuals that deal with the database.

20 Q. But for each of the 340 entries
21 listed for the year 2016 in Summit County, if we
22 wanted to determine whether they were, at some
23 point, prescribed a lawful opioid prescription,
24 we'd have to do a case-by-case analysis to
25 determine whether that was the case or whether

1 we couldn't make that determination?

2 MS. HERMIZ: Objection to form.

3 Q. Do you understand my question?

4 A. No.

5 Q. Okay. If we wanted to find out
6 whether any one of the 340 individuals listed on
7 Exhibit 2 had a lawful prescription of an opioid
8 at some point, we would have to do a
9 case-by-case determination; is that right?

10 MS. HERMIZ: Same objection.

11 A. You mean a case-by-case
12 investigation?

13 Q. Yes.

14 A. Yes, you would.

15 Q. And amongst the things that -- that
16 one might look at to at least see if you could
17 find that answer was to look at the OARRS
18 database, right?

19 A. You could, yes.

20 Q. You would also want to look back at
21 the file to determine if there was any medical
22 records, right?

23 A. You could. You could do that.

24 Q. You would look at the medical
25 records and the prescription records?

1 MS. HERMIZ: Objection to form.

2 A. Well, you mean the decedent's
3 medical records, go back to the decedent's
4 medical records?

5 Q. Yes.

6 A. You could -- you would have to --
7 and you're referring to the medical records of
8 all of these other potential agencies, such as
9 primary care physicians and hospitals and so
10 forth?

11 Q. Those would be amongst the resources
12 or -- or individuals or entities of which you
13 could go if you wanted to answer that question,
14 right?

15 A. You mean me, me personally --

16 Q. Somebody.

17 A. -- I would go? For you, or an
18 individual doing what you're suggesting, you
19 would have to address HIPAA laws, and then you
20 could proceed with your investigation.

21 Q. But you're not bound by those same
22 HIPAA laws, are you?

23 MS. HERMIZ: Objection to form.

24 A. No. Of course, we're bound by HIPAA
25 laws.

1 Q. Okay. So would the way you -- I do
2 the investigation differ from the way that you
3 do it?

4 MS. HERMIZ: Objection to form.

5 A. The medical examiner office can
6 perform death investigations to the extent of
7 the needs of the medical examiner's office. So
8 the medical examiner is charged with determining
9 cause and manner of death to a reasonable degree
10 of medical certainty. That doesn't give us free
11 rein to, you know, query all aspects of the
12 decedent's past necessarily, but it does give us
13 ability to determine or investigate issues
14 specifically addressing cause and manner of
15 death.

16 Beyond that, we generally don't
17 pursue additional investigation if it's
18 exceeding the scope of the needs of the medical
19 examiner's office to establish cause and manner
20 of death to a reasonable degree of medical
21 certainty.

22 Q. Amongst the tools available to you
23 if you believe that you need to do -- to access
24 them is to ask a primary care physician to
25 provide you medical records; that would be

1 something that would be within the scope of your
2 abilities if, in a particular case, you
3 determined that it was appropriate?

4 A. Yes. We can request medical records
5 from other -- from physicians that treated the
6 decedents during life.

7 Q. And you could request hospital
8 records?

9 A. Yes.

10 Q. And you could request pharmacy
11 records, or prescription records?

12 A. We do not routinely request records
13 from individual pharmacies. So I can't really
14 answer or address that question. But physician
15 records will include prescription -- current
16 prescriptions and past prescriptions, depending
17 upon the individual physician offices and how --
18 and their individual recordkeeping.

19 Q. Are there any limitations on the
20 records that you could obtain -- strike that.

21 Are there any limitations on the
22 types of healthcare records that you could
23 obtain if you, in your considered professional
24 judgment, determined that it was necessary for
25 your investigation?

1 MS. HERMIZ: Objection to form.

2 A. I'm not -- I'm not really sure if I
3 understand what you mean by healthcare records.
4 I can address what is routinely requested. The
5 extent of the investigation, once again, is
6 going to be directed to addressing cause and
7 manner of death. I mean, some restrictions, for
8 example, are, we, as the office, simply might
9 not be able to access records if physicians have
10 retired and the medical records are just no
11 longer available. We might -- I might want to
12 get other records, but they just might not be
13 available. And hospitals, for example, have
14 kept records on -- you know, paper records up
15 until very, very recently, and in many instances
16 it becomes not practical to obtain records that
17 are filed away, or to delay a certification of
18 death for many months if records are not readily
19 available, if it's not essential for determining
20 cause and manner of death.

21 So there is always potential
22 limitations to the records that I can obtain,
23 but we do make an attempt to obtain records that
24 are necessary for determining cause and manner
25 of death.

1 Q. It's a fair point. And to maybe put
2 a finer point on my question, putting aside the
3 impracticality or kind of the impossibility,
4 right, of a doctor who may have died or a fire
5 or something like that, what I'm just trying to
6 find out is, is there any SOP, any rule or
7 restriction that would prevent you from even
8 asking for healthcare records to the extent that
9 you believed it was appropriate?

10 A. There's no HIPAA restrictions for
11 the medical examiner's office to obtain medical
12 records on decedents that we are actively
13 investigating pursuant to the determination of
14 cause and manner of death, no HIPAA
15 restrictions, at least that I'm aware of. If
16 there is some type of restriction, I am unaware
17 of one.

18 Q. In your experience -- I'm sorry. Go
19 ahead.

20 A. I'll qualify that.

21 For example, I am restricted by
22 HIPAA laws from obtaining medical records from
23 non-decedents that might be related to the
24 decedent. For example -- I can't obtain medical
25 records on other family members, for example.

1 Q. As a general matter, and I'm not
2 referring to any specific, though I've seen some
3 general references, if someone has a stroke and
4 also has a tox test that shows methamphetamine
5 or some other illicit medicine or drug, will
6 that cause of death or manner of death typically
7 be assigned a drug overdose?

8 MS. HERMIZ: Objection to form.

9 A. It is difficult to just generically,
10 out-of-hand say that all deaths of a certain
11 type out of necessary -- necessarily will be
12 certified one way or the other; so in this
13 hypothetical that you're giving, you have an
14 individual that is actively abusing drugs, using
15 illicit drugs, but they also have a significant
16 natural event or potentially natural event or
17 significant anatomic event, like a stroke, so
18 that individual case is going to be examined and
19 considered for the -- for the issues for that
20 individual person, and then a determination will
21 be made based upon the merits of their -- of
22 their findings. It could be certified as a drug
23 overdose or it could be certified as a non-drug
24 toxicity based upon the merits of the specific
25 findings of that specific case.

1 Q. And if it's -- is there a bias one
2 way or the other? In other words, if there's --
3 if you can't, obviously, determine certainty,
4 but in that typical case, would there be a bias
5 to list it as drug overdose as a matter of
6 office policy?

7 MS. HERMIZ: Objection to form.

8 A. Do you mean is it the policy of the
9 Summit County Medical Examiner's Office to rule
10 one way or the other if there is combined
11 post-mortem findings?

12 Q. Yes. Is there some type of general
13 bias -- and I think you know what that means,
14 and I don't mean it in a pejorative sense, but
15 is there a bias that if someone has
16 methamphetamines at the time of death and they
17 also had a stroke, that it would be listed as a
18 drug overdose?

19 MS. HERMIZ: Same objection.

20 A. That's not the way death
21 certification works. There aren't arbitrary
22 office policies for death certifications that I
23 or the other forensic pathologists practicing in
24 the office follow or are bound to follow. The
25 merits of each individual case need -- are

1 evaluated and an appropriate certification is
2 done with an intent to achieve reasonable degree
3 of certainty.

4 So, for example, two individuals
5 with -- who are actively abusing drugs and
6 actively have an anatomic finding, like a
7 stroke, can have different rulings based upon
8 the unique finding -- their personal unique
9 findings. Everybody has a face, we all have two
10 eyes, a nose and a mouth, but everyone looks a
11 little bit different, so each case can be
12 potentially a little bit different, and the
13 merits of each case need to be individually
14 considered.

15 Q. And you've mentioned that a few
16 times. That's very important in your analysis,
17 that every case stands alone and every case has
18 to be looked at individually, right?

19 A. Yes.

20 Q. And you also just testified that a
21 factor at least that weighs into this analysis
22 is whether someone is actively abusing drugs, or
23 may weigh into it, right?

24 A. Yes. That would be considered, yes.

25 Q. So how would you determine if

1 someone is actively abusing drugs?

2 MS. HERMIZ: Objection to form.

3 A. An investigation can support that an
4 individual is actively abusing drugs, for
5 example, by the presence of drug paraphernalia
6 identified at the scene, by the presence of
7 physical stigmata of active drug abuse, such as
8 intravenous needle punctures and prior needle
9 tracks.

10 Q. Anything else?

11 A. There's probably other -- other
12 criteria that's just eluding my mind at this
13 moment.

14 Q. I suppose if your investigator
15 talked to a friend or family member and they
16 said, this is a terrible -- you know, John or
17 Susie has been actively abusing drugs for a
18 number of years, that would make its way into
19 the investigation report, right?

20 A. You mean history, history of active
21 drug abuse?

22 Q. Yes.

23 A. Yes. If a history of active drug
24 abuse is elicited, that is probably going to be
25 documented in the investigation report, and that

1 would be considered.

2 Q. And that's one of the things that
3 the investigators look for, correct?

4 A. Yes. The investigators will
5 document a history -- a history of prior drug
6 use if that history is available.

7 Q. In your estimation, is Summit County
8 currently facing any type of drug epidemic
9 either from lawful prescription drugs or illicit
10 drugs?

11 MS. HERMIZ: Objection to form.

12 A. Yeah. I think the term "drug
13 epidemic" is used in a non-medical,
14 non-scientific way, the way the term "heart
15 attack" is being used. I cannot provide
16 testimony to the extent to which Summit County
17 is experiencing an epidemic in terms of how a
18 epidemiologist would define epidemic, but Summit
19 County is experiencing a serious issue with
20 drug-related deaths, and the majority of which
21 are associated with, you know, obviously drug
22 abuse.

23 Q. And currently is that related to
24 cocaine and methamphetamine?

25 MS. HERMIZ: Objection to form.

1 A. Currently, you mean like right now?

2 Q. Like 2018.

3 A. Like 2018. It's been my personal
4 experience with my cases that, in 2018, the
5 majority of the drug deaths which I have
6 certified have been due to what can be termed
7 illicit street drugs, fentanyl analogs, fentanyl
8 itself that's non-prescription, cocaine and
9 methamphetamine.

10 Q. And maybe you could just help me
11 understand your -- your reluctance, and you can
12 tell me if it's a different word you'd like to
13 use, to classifying the current situation as an
14 epidemic.

15 A. It's my impression that the
16 classification, or referring to the drug use
17 fatalities as an epidemic is being used in terms
18 of a common sense, like heart attack -- the term
19 "heart attack" and "stroke." It might be being
20 used in terms of specific epidemiologic studies,
21 but I have not reviewed those.

22 Q. Can you recall a case or a situation
23 in your experience where the cause of death was
24 from a prescription opioid medicine where the
25 patient was using it as indicated and as

1 prescribed?

2 A. I don't have a crystal ball. I
3 can't go back in time and watch an individual
4 use their drugs. So in an instance of
5 prescription medications, I can't go back in
6 time and watch them take their prescription
7 drugs. I can only evaluate the information
8 available to me. So if I -- if an individual is
9 coming to me, they are dead. If an individual
10 is coming to me and I'm ruling their death as
11 due to a drug which they have a legitimate
12 prescription for, they have a -- the
13 investigation has supported that they died due
14 to that amount of drug, the ruling that they
15 died due to the -- of a drug overdose with a
16 substance that is prescribed to them isn't
17 necessarily a ruling that they were or were
18 not -- or how they were taking their
19 prescription medications necessarily.

20 So your specific question, I mean,
21 the most -- for the most part, it's not
22 something that I -- I consider in terms of my
23 ruling.

24 Q. And I understand that, Doctor, and
25 that's why it was a specific question. Putting

1 all of the caveats that you just put, that it
2 may not be something that you traditionally do,
3 my question was just, very simply, in the course
4 of your practice can you remember a situation
5 where, through investigation or some other
6 facts, you learned of a person who had been
7 prescribed a lawful opioid and had been taking
8 it consistent with their prescription and had
9 somehow died from that? Can you remember any
10 situation where that actually happened and you
11 had information of it?

12 A. I would point out that once someone
13 is taking the prescription medications outside
14 of a clinical setting, I can never say with
15 certainty that they're taking their medications
16 properly or not, so I -- I don't know for those
17 individuals. I have had individuals who have
18 died in a hospital setting on rare occasions
19 receiving opioid medications.

20 Q. And has the cause of death been the
21 opioid medications?

22 A. Yes.

23 Q. And has that been an overdose
24 situation?

25 A. It's been a drug toxicity.

1 Q. And that's in hospital settings?

2 A. Yes.

3 Q. Anything else? Any other situations
4 that you can recall?

5 A. Those are the only settings where I
6 can have certainty that an individual is taking
7 their medication specifically as prescribed,
8 because it's being given to them as prescribed.

9 Q. Okay. Would you please look at --
10 it's page 23 of 46 of this document.

11 MS. HERMIZ: Is there a Bates
12 number?

13 MR. CHEFFO: There is. There's also
14 a page number.

15 MS. HERMIZ: Oh, okay. I didn't see
16 the page number. I apologize.

17 MR. CHEFFO: I can read the whole
18 long thing.

19 MS. HERMIZ: No. That's okay.

20 Q. Are you with me, Doctor?

21 A. Um-hum.

22 Q. 55702, do you see that? It's, like,
23 near the bottom.

24 A. Yes.

25 Q. 7-27-2016. I think you understand,

1 but just for the record, when I talk about
2 55702, I'm talking about the case number on the
3 far left hand, right?

4 A. Yes.

5 Q. That's how you assign some kind of
6 identifying feature to a particular person as
7 opposed to using their name; is that right?

8 A. Yeah. So all decedents will have a
9 case number, but they also have a name, so we
10 can search for individuals based upon their name
11 or based upon their case number.

12 Q. Now, I have a few questions about
13 this one.

14 So this basically says the manner of
15 death is accident, right?

16 A. Yes.

17 Q. The type of death is drug overdose.
18 Do you see that?

19 A. Yes.

20 Q. Then the cause of death is
21 carfentanil toxicity, right?

22 A. Yes.

23 Q. Now, carfentanil is a fentanyl
24 analog that's an illegal street drug, right?

25 A. Yes.

1 Q. Under the tox results it says, "None
2 detected." Do you see that?

3 A. Yes.

4 Q. And we can go through this chart,
5 but there's a number of times where it says,
6 "None detected," particularly with respect to
7 carfentanil in terms of the tox, but yet the
8 cause of death is fentanyl -- I'm sorry,
9 carfentanil toxicity.

10 My question for you, Doctor, is, can
11 you help us understand how a determination would
12 be made that a cause of death is carfentanil
13 toxicity when there's no tox results showing
14 carfentanil?

15 A. So for each of these instances in
16 this database printout, to know the specific
17 reason why an individual is listed as a
18 carfentanil toxicity accidental drug overdose,
19 one would have to go back and review that
20 specific case. It could be that car -- well,
21 carfentanil is a very, very potent fentanyl
22 analog, and it's potentially toxic and fatal at
23 levels that are lower than the limit of the
24 methodologies available to the Summit County
25 Medical Examiner. So then other criteria would

1 be used to support that the individual was
2 using -- abusing carfentanil at the time of
3 their death, such as, you know, a syringe next
4 to the body with -- that is positive for
5 carfentanil, and it appeared that the
6 individual -- it was reasonable to presume that
7 the individual had injected, for example.

8 Q. Okay. I mean, other than a syringe,
9 what other factors, in your professional
10 judgment, would -- would you look at or have you
11 looked at, kind of from a broad spectrum, in
12 cases where a tox screen shows no carfentanil
13 detected but yet you've been able to make a
14 determination that carfentanil is the likely
15 cause of death?

16 MS. HERMIZ: Objection to form.

17 A. So one can -- so any criteria that
18 helps establish a reasonable degree of
19 certainty.

20 There could be a carfentanil drug
21 positive paraphernalia. That could be a
22 syringe. That could be carfentanil positive
23 powder. The individuals might have urine that
24 is positive for carfentanil. There -- it could
25 be a group overdose of individuals that are

1 abusing the same batch of drugs, and some of the
2 other individuals in that group could
3 successfully have carfentanil confirmed in their
4 post-mortem specimens. It's just a combination
5 of factors like that.

6 Q. Those -- it sounds to me at least,
7 those are all kind of circumstantial around the,
8 kind of, place and location of death, right, at
9 least the ones -- the examples you've given?

10 MS. HERMIZ: Objection to form.

11 Q. They're with other people perhaps,
12 they have a syringe, they have powder next to
13 them, things like that, right?

14 A. So these are criteria that are other
15 than confirming the presence of carfentanil in
16 their blood.

17 Q. And are there other things, in terms
18 of medical records you might look at or in the
19 investigation report, that would also point to a
20 carfentanil cause of death when it's not
21 detected in their blood?

22 A. I'm not sure what you're getting at.

23 Q. I'm just asking a question, Doctor.
24 We've spent some amount of time saying that what
25 you do as a medical examiner is to have a

1 reasonable degree of cause of death, and I'm
2 just trying to understand when something is
3 listed to a reasonable degree, like carfentanil
4 toxicity, and it's not detected, what are some
5 of the factors in your professional experience
6 that could lead you to conclude, to a reasonable
7 degree of certainty, that someone actually died
8 of carfentanil when it's not detected in their
9 tox results. You've given me a few factors.
10 I'm just trying to find out and probe if there
11 are any others that you can think of.

12 A. As with a potential carfentanil
13 death -- I mean, as with any potential drug
14 overdose death, including carfentanil, the -- a
15 complete investigation will be done to the
16 extent that it's practical and reasonable to do.
17 Individuals will be interviewed, if there are
18 individuals to be -- to be interviewed, such as
19 other individuals that were present at the time
20 the decedent was found deceased. Family members
21 will be interviewed, if they're available to be
22 interviewed. Carfentanil is a large animal
23 anesthetic agent. It doesn't have any clinical
24 applications in humans that I am aware of. I
25 am, therefore -- therefore, it won't appear on

1 an OARRS screen and it won't appear in medical
2 records because it's not a prescription drug.

3 And then a complete death -- I mean,
4 autopsy examination is performed. Based upon
5 the physical findings and the weight of the
6 investigation and the scene investigation, a
7 determination for cause of death of a
8 carfentanil toxicity in an individual where
9 there is either -- it's not possible for the --
10 the toxicology laboratory to confirm the
11 presence of carfentanil in blood, or it's
12 perhaps detected but not the -- the amount is
13 not large enough to report, the -- in those
14 instances the -- whether or not a death will be
15 classified as a carfentanil toxicity drug
16 overdose accident will be based upon the merits
17 of the -- of that specific case.

18 As I've previously talked about,
19 there might be drug paraphernalia present. That
20 could be a syringe, it could be powder. There
21 might be carfentanil in a person's other --
22 other specimens other than blood. It could be
23 in their urine. Carfentanil could be in other
24 individuals that are found deceased at the scene
25 even if it can't be confirmed in that -- in a

1 specific individual.

2 Q. We've talked about some of your
3 areas of expertise. Are you an expert or do you
4 hold yourself out as an expert in addiction?

5 A. I -- you know, I'm a licensed
6 physician in the State of Ohio and I've been
7 licensed to practice medicine in other states,
8 so to the extent that I'm a physician, I can
9 offer opinions to addiction to the extent that
10 it affects my practice immediately. I am not a
11 clinical physician that deals with living
12 individuals who are -- I don't deal with
13 management of patients -- of living patients for
14 addiction. So I cannot offer expert opinion
15 regarding the most current standards of
16 practices -- practice for drug addiction
17 management.

18 Q. So how does addiction then come into
19 play in your practice?

20 A. Well, people who are drug addicts do
21 tend to become my patients with some frequency.

22 Q. And what is it -- have you studied
23 addiction in any regard? How does that
24 interplay with your work?

25 A. Well, once again, I'm a physician.

1 I've -- I'm aware of addiction, and people who
2 are drug addicts do become my patients with some
3 frequency, and I need to be aware of what type
4 of -- of drug addiction management is occurring
5 to evaluate the deaths which come to me and make
6 a ruling for cause and manner of death to a
7 reasonable degree of certainty.

8 Q. Why does the manner of or the
9 process or the procedures for drug addiction
10 impact your day-to-day work?

11 A. People who are actively being
12 treated for drug addiction sometimes overdose
13 and die and they become my patients.

14 Q. So do -- so is it important that you
15 find out those records, as to whether they are
16 being treated for drug addiction?

17 MS. HERMIZ: Objection to form.

18 A. I obtain records with the direction
19 of determining cause and manner of death. When
20 it is important to obtain a record for a
21 specific individual for determining cause and
22 manner of death, I -- I or someone at the office
23 will be charged with doing so.

24 Q. And that would be records regarding
25 drug addiction treatment, correct?

1 MS. HERMIZ: Objection to form.

2 A. It could be.

3 Q. When was the last time you reviewed
4 a record for drug addiction treatment of any
5 decedent?

6 A. Within the past few weeks.

7 Q. And what was the circumstances of
8 that?

9 A. It was an individual who died who
10 was receiving methadone through a methadone
11 clinic, or a drug addiction clinic.

12 Q. And how did it come to pass that
13 those records were collected?

14 A. When it became -- when -- when the
15 office was made aware that the individual was in
16 a drug treatment program, the records were
17 requested.

18 Q. And that was one of your patients?
19 Do you call them patients?

20 A. Patients, decedents.

21 Q. That was a case you were working on?

22 A. Yes.

23 Q. And is that something that you
24 directed or is it something that the
25 investigator, in his or her kind of just work

1 experience, goes out and does?

2 A. In that specific instance, I
3 directed the investigator to make the request,
4 but the investigator can do it independently if
5 they're aware.

6 Q. And how did you know that that
7 person was in a drug treatment program?

8 A. We were ultimately told, "we"
9 meaning the office was told.

10 Q. By?

11 A. By -- in that specific instance, it
12 was through a civil lawsuit.

13 Q. So -- I don't want to get into the
14 details of that, but there was a lawsuit that
15 made you aware that there was an individual who
16 was a decedent, your case, who was receiving
17 drug treatment; is that right?

18 A. Yes.

19 Q. And then that -- with that knowledge
20 that there was drug treatment, you determined to
21 ask someone in your office to get any records
22 for that person, correct?

23 MS. HERMIZ: Objection to form.

24 Q. Get any records from the drug
25 treatment facility?

1 A. Yes.

2 Q. And they complied?

3 A. They did.

4 Q. And how was that information used by
5 you?

6 A. What do you mean, "used"?

7 Q. Well, I take it you wanted the
8 records for some purpose, right, or else you
9 wouldn't have requested them?

10 A. Yeah. I wanted the records to
11 review the records. That was the purpose.

12 Q. You weren't looking to waste the
13 time of the clinic, right?

14 A. Yeah. I wanted the records to
15 review them.

16 Q. But why?

17 A. Because that was part of that
18 individual's -- because it was related to their
19 death certification, the issues of their death
20 certification, their cause and manner of death.

21 Q. Well, yeah. And maybe this is
22 intuitive to you, so forgive me. I'm not sure
23 that I understand, so that's why I'm going to
24 ask you some questions about it. You understood
25 that the person had -- the cause of death was a

1 drug overdose, right?

2 A. Yes.

3 Q. And that determination was -- well,
4 strike that.

5 How did the records that you
6 received from this clinic or this treatment
7 facility inform your view as to the cause of
8 death?

9 A. It was confirmation that the
10 individual was in a drug treatment program.

11 Q. And why did you want that
12 confirmation in order to determine, to a
13 reasonable degree of certainty, that the person
14 died of a drug overdose?

15 A. I didn't need the information to be
16 certain that they died of a drug overdose, but
17 they did die due to a drug overdose, so the fact
18 that they were in a drug treatment program was
19 part of their evaluation for their -- that
20 specific individual for cause and manner of
21 death.

22 Q. And before you received them, was
23 there some information that you believed might
24 be pertinent to your analysis that you wanted to
25 explore?

1 A. Yes. I wanted to confirm that they
2 were indeed in a drug treatment program at the
3 time of their death.

4 Q. And how did the fact that they were
5 in a drug treatment program as opposed to they
6 were not in a drug treatment program, how would
7 that have impacted your determination?

8 A. Well, in this instance, it didn't
9 change the cause and manner of death, so we
10 didn't -- it didn't alter the determination for
11 cause and manner of death.

12 Q. But you believed it was appropriate
13 to ask for it and there may have been
14 information that could have helped you and you
15 thought it was medically appropriate and
16 professionally appropriate to get that
17 information because it was part of the
18 constellation of facts and information that you
19 wanted before you made a final determination; is
20 that right?

21 A. Well, I was within my jurisdiction,
22 within the -- I didn't exceed my jurisdictional
23 investigational limits to request those reports,
24 I had every right to request them. So I'm not
25 really sure what you're asking.

1 Q. You made a determination that you
2 thought it was both appropriate and potentially
3 informative to request that information, so you
4 did, and you got it, and you waited until you
5 received it, then you made a final
6 determination?

7 MS. HERMIZ: Objection to form.

8 A. No. I didn't do it in that form.

9 Q. How did you do it?

10 A. In that specific instance, the death
11 certification was completed because, at the time
12 of the certification, it wasn't evident by our
13 initial investigation that that individual was
14 actively in a drug treatment program.

15 Q. Oh, so if you get information after
16 the fact, it's appropriate for you to continue
17 to request records in connection with a decedent
18 even though you had previously made a
19 determination, as you just testified to?

20 MS. HERMIZ: Objection to form.

21 A. It could be appropriate. It's
22 not -- it's not necessarily appropriate. It's
23 not necessarily necessary. I mean, it's not
24 absolutely necessary. It depends on the
25 circumstances.

1 Q. I assume, since you did it, you
2 think it was appropriate in this case, right?

3 A. In this specific instance, I -- in
4 this specific instance, I did obtain the records
5 after the certification had already been
6 completed.

7 Q. Would you do that if you thought it
8 was inappropriate?

9 MS. HERMIZ: Objection to form.

10 A. If it was not within -- if I did not
11 have the authority, if it was inappropriate for
12 me to request the records, if I did not have the
13 authority to request the records, I would not
14 have.

15 Q. Is it your testimony that as long as
16 you have the authority -- strike that.

17 When you made the determination to
18 ask for more records, did you believe it was an
19 appropriate thing to do?

20 MS. HERMIZ: Objection to form.

21 A. I think we're having a difference of
22 concept of the word "appropriate." It's -- I --
23 there are some records that I can request and
24 it -- because this individual died within the
25 jurisdiction of the Summit County Medical

1 Examiner, then it was certainly appropriate for
2 me to request medical records from any medical
3 provider. I had the authority to do it. It was
4 appropriate for me to do it. It's not -- it's
5 not absolutely necessary for me to request all
6 medical records from all potential medical
7 providers for every decedent, not even practical
8 or possible; but, in this instance, I did it
9 because it was part of the -- it was brought to
10 the attention of the medical examiner's office
11 through the civil lawsuit that the individual
12 was in a methadone treatment program.

13 Q. So the answer is yes, you did it
14 because you thought it was appropriate because
15 you wouldn't knowingly do something that you
16 thought was inappropriate, right? Isn't that
17 the answer?

18 MS. HERMIZ: Objection to form.

19 A. Well, it's appropriate, I had the
20 authority to do it, so it wasn't inappropriate
21 for me to request the records. It wasn't
22 necessary to have those records to draw the
23 ultimate determination for cause and manner of
24 death. Those records did not alter the cause or
25 manner of death.

1 Q. But you didn't know that until after
2 you reviewed the records, right?

3 MS. HERMIZ: Objection to form.

4 A. Well, in this instance, I think I
5 did know that it wasn't necessary for cause and
6 manner of death. I didn't need those records to
7 make the determination for cause and manner of
8 death in that specific instance, but it was
9 brought to the attention of the medical examiner
10 that that individual was in a methadone
11 treatment program and at the time of the death
12 it wasn't clear -- clearly -- that part of the
13 medical history wasn't clearly defined at the
14 time of the certification, though it wasn't
15 necessary for the certification, and because
16 there was an active civil lawsuit, I did request
17 those records because I had the authority to do
18 so.

19 Q. So you had the authority to do it
20 but it wasn't necessary, but you still went
21 ahead and requested the records?

22 A. It wasn't necessary for the
23 determination for cause and manner of death, but
24 it wasn't inappropriate for me to request those
25 records. We -- the medical examiner will often

1 request -- receive more records than what's
2 absolutely necessary for determining cause and
3 manner of death because, until I review those
4 records, I don't know what's absolutely
5 necessary for determining cause and manner of
6 death.

7 If those records in that specific
8 instance affected or had a significant effect on
9 the initial ruling for cause and manner of
10 death, I could change the ruling for cause and
11 manner of death. As it so happened, it didn't
12 make a difference.

13 Q. I'm just trying to understand. So
14 you basically just told us, though, you didn't
15 think it was necessary because you said you
16 didn't believe it was going to change your view,
17 you thought it was appropriate, but what
18 authority do you have to request records that
19 you don't think are necessary? Do you think
20 that's within the scope of your authority?

21 MS. HERMIZ: Objection to form.

22 A. Okay. So I can request records
23 pursuant to a death investigation. I can't -- I
24 won't always know what records are going to be
25 essential for the death investigation until I

1 receive them and review them.

2 Q. All right. So information came to
3 you, you wanted to receive it so you could then
4 look at the records to determine if your initial
5 judgment was correct or not; isn't that what
6 happened?

7 A. Yes, in part.

8 Q. Okay. And that was an appropriate
9 thing to do, right, under the -- whatever
10 definition, the nomenclature, the general
11 understanding that a person like you, I'm
12 assuming, would not intentionally do something
13 inappropriate, right? This shouldn't be a hard
14 question, Doctor.

15 A. It was within my authority to do
16 that, to request those records in that specific
17 instance.

18 Q. Okay. And, similarly, in other
19 situations, to the extent that new information
20 becomes available, it would be within your
21 authority, or the department's authority, to
22 request additional records of people like drug
23 addiction centers and others, correct?

24 A. Each individual case would have to
25 be evaluated to see if additional information is

1 necessary, or would it be necessary, or would it
2 be appropriate to request.

3 Q. And I assume you're not going to
4 tell us under oath that the only reason you did
5 this was because you had a civil lawsuit
6 pending, right? There had to be some legitimate
7 reason, other than a civil lawsuit, where you
8 thought that it was appropriate to ask for more
9 records, right?

10 MS. HERMIZ: Objection to form.

11 A. In that specific instance, the
12 certification for cause and manner of death,
13 it's my opinion then, it's my opinion now, was
14 correct and appropriate. The additional
15 information or the additional records did not
16 alter that classification for cause and manner
17 of death.

18 Q. But the point is, it didn't change
19 it, we know that, because you had a chance to
20 look at it. But when you made the determination
21 to ask for those, I take it you thought that was
22 a legitimate, appropriate request and you had an
23 open mind as to what that information might show
24 as a medical professional, and then you reviewed
25 it and then you determined that it didn't change

1 your initial finding, right?

2 MS. HERMIZ: Asked and answered.

3 A. Wow, it's like we're talking in the
4 dark here, though.

5 Q. I think the lights are on, at least
6 on this side of the room.

7 A. This specific individual had active
8 intravenous drug abuse, and the -- the issue of
9 whether or not they were actively in a drug
10 treatment program was not going to make a
11 difference in whether or not -- for their cause
12 of death.

13 Q. Then why did you request it?

14 A. I requested the -- the confirmation
15 records to confirm that they were indeed in a
16 drug treatment program.

17 Q. And determining whether someone is
18 in a drug treatment program is a legitimate
19 inquiry as part of the medical examiner's
20 office's work in appropriate cases?

21 A. Yes.

22 Q. Can you look at page 26 of 46,
23 please, 55751? Do you see that?

24 A. Which case?

25 Q. 8-13-2016. It's 55751. Do you see

1 that?

2 A. Yes.

3 Q. And you may tell me that you don't
4 have specific recollection of this case, but I
5 just -- is there anything that you can tell us
6 as to why, when the only -- there's a tox result
7 here that shows oxycodone, 178 nanograms per
8 millimeter, but the cause of death is
9 carfentanil and there's no cause of death
10 attributable to oxycodone. Do you have an
11 explanation as to why that might be?

12 A. I can't say why that is with the
13 information here.

14 Q. Are there some potential
15 explanations based on your experience?

16 A. I can presume that -- I don't recall
17 who this individual is. I don't recall this
18 specific decedent being one of my personal
19 investigations, so I'm not sure why this
20 specific individual was listed as a carfentanil
21 toxicity with a presence of oxycodone in the
22 blood.

23 Q. It's a fair point, right, you don't
24 have a lot of information, this is from a few
25 years ago, so I'm not asking you to opine on

1 this specific case; but again, as an expert in
2 this field, what would some explanations be that
3 you could think of as to why someone would be
4 classified as a cause of death being carfentanil
5 toxicity when there's no tox results for
6 carfentanil and the only tox results show
7 oxycodone and there's no listing of oxycodone
8 being a cause of death? Do you have any
9 potential explanations as to what factors may
10 have driven that determination?

11 A. I mean, we don't have to guess. A
12 case -- a case folder exists. One could just go
13 back and look at the specific case and see what
14 the parameters were for this specific case, why
15 this individual has carfentanil listed as the
16 cause of death and oxycodone was not included.

17 Q. But as you sit here today, you can't
18 shed any more light on that; is that fair?

19 A. My presumption is that the
20 investigation supported that the individual was
21 actively abusing carfentanil.

22 MR. CHEFFO: Let's mark this,
23 please, as 3.

24 - - - - -

25 (Thereupon, Deposition Exhibit 3,

1 E-Mail from Patrick Gillepsie to
2 Steve Perch, dated January 31, 2017,
3 with Attachment, Beginning Bates
4 Number SUMMIT_000118414, was marked
5 for purposes of identification.)

6 - - - - -

7 Q. So let me just orient you as to what
8 I think this is. So this is also produced --
9 you'll see the Summit County Bates numbers here,
10 and it's from 8-1-2016 to 1-31-2017.

11 Do you see that?

12 A. Yes.

13 Q. It's basically, you know, August to
14 January, whereas the prior exhibit was the full
15 year.

16 A. Yes.

17 Q. And then there's 14 pages in this
18 document. I also just want to orient you.
19 There's a date. I assume it's when it's printed
20 out, though I don't know that for a fact, but
21 it's January 31st, 2017. Do you see that?

22 A. I do.

23 Q. And that's in contrast to the
24 Exhibit 2 -- Exhibit 2, I think, which is
25 January 3rd, 2018, so approximately a year

1 later. Are you with me? The one we've been
2 talking about.

3 A. Yes.

4 Q. Now, if you look at -- if you look
5 at Exhibit 2 for a minute. You may just want to
6 put them side by side because I'm going to ask
7 you -- there's a few I want to compare. Exhibit
8 2, page 24, and I'm going to ask you to look at
9 55719.

10 Are you with me?

11 A. Yes.

12 Q. So in the entry with a printout from
13 January 3rd, 2018, for that tox result it says,
14 "None detected."

15 A. I'm sorry. Which one?

16 Q. That's a fair point. I'm on the
17 Exhibit 2, 55719, page 24 of 46, and I'm in the
18 toxicology result, and it says, "None detected,"
19 but it has a cause of death as carfentanil
20 toxicity.

21 A. Yes.

22 Q. And then I'd like to -- you can hold
23 that place, if you would -- direct your
24 attention to Exhibit 3, which I just gave you,
25 and if you look at the same entry, 55719, on the

1 printout from a year earlier the tox results
2 say, "carfentanil present." Do you see that?

3 A. Yes.

4 Q. Do you -- strike that.

5 And if you look at the other
6 information, it looks to me like this is a
7 44-year-old white female, right? The address
8 looks to be the same, right?

9 A. Yes.

10 Q. And you don't use redundant case
11 numbers, right? In other words, we would expect
12 that 55719 to carry through?

13 A. Yes.

14 Q. So do you know why it would be that
15 one report a year earlier says carfentanil was
16 present, but later, when the same case is run,
17 it says none detected?

18 MS. HERMIZ: Objection to form.

19 A. I don't know why.

20 Q. Does that concern you at all?

21 MS. HERMIZ: Objection to form.

22 A. Once again, I don't -- I don't enter
23 the database. I don't -- I don't know why
24 there's a discrepancy on the two printouts.

25 Q. It's not a matter of entering,

1 though, right? Wouldn't you have had to change
2 the database, because the earlier one has
3 carfentanil present and then a year later it
4 says none detected, right?

5 A. I think -- I think one would have to
6 refer back to the specific case.

7 Q. Under what circumstances would
8 that -- I mean, that's not the only one, Doctor.
9 Look at 55724, just two below it, and then
10 55725, 55741. I mean, there's multiple examples
11 where someone apparently changed it to say that
12 carfentanil was not detected whereas, in an
13 earlier version, it said it was detected.

14 MS. HERMIZ: Objection to form.

15 Q. Do you have any explanation for
16 that?

17 A. I don't.

18 Q. If you had seen this outside this
19 scope of a deposition, would that have raised
20 questions in your mind?

21 MS. HERMIZ: Objection to form.

22 A. I would go back and look at the
23 individual case folders.

24 Q. You would?

25 A. If you -- if there was a question.

1 I didn't run the parameters here. I don't know
2 what parameters were put in. And I didn't -- I
3 don't enter the case data into the database.

4 Q. And you've made that clear. You're
5 not the data entry person, so my question is not
6 focused on who did that. I'm just asking you,
7 having seen this information as a professional
8 in the office, does this raise some questions
9 and concerns in your own mind?

10 A. No.

11 Q. None? You don't have any -- having
12 seen the information that you can't explain --
13 well, strike that.

14 Are these reconcilable?

15 MS. HERMIZ: Objection to form.

16 A. I would refer back to the
17 individuals who are running the -- the actual
18 queries.

19 Q. You're the deputy chief medical
20 examiner, right?

21 A. The chief deputy medical examiner,
22 that's correct.

23 Q. Chief deputy.

24 As the chief deputy medical
25 examiner, can you tell me how these entries on

1 these two different exhibits can be reconciled,
2 where one says none detected and the other one
3 says carfentanil? Do you have an explanation
4 for that?

5 MS. HERMIZ: Asked and answered.

6 A. I think one could go back and look
7 at the individual cases and see what the
8 explanation is.

9 Q. And are you going to do that?

10 MS. HERMIZ: Objection to form.

11 A. Are you telling me I need to do
12 that?

13 Q. My question was, are you going to do
14 that? Do you feel a sense of obligation, having
15 had this brought to your attention, to find out
16 why that information is inconsistent?

17 MS. HERMIZ: Objection to form.

18 A. Reconciling the statistics generated
19 are not specifically within my duties.

20 Q. These are not statistics, though,
21 are they?

22 MS. HERMIZ: Objection to form.

23 Q. These are facts.

24 MS. HERMIZ: Objection to form.

25 Q. Are they facts or statistics?

1 MS. HERMIZ: Objection to form.

2 A. Well, this is the printout from
3 which statistics are going to be generated from,
4 or this type of query is the format in which
5 statistics are going to be generated from.

6 Q. Well, gosh, doesn't that make it
7 even more important then; if you know you're
8 going to generate statistics from information,
9 don't you want to make sure it's actually
10 accurate?

11 MS. HERMIZ: Objection to form.

12 He's already testified he doesn't do
13 statistics.

14 MR. CHEFFO: That's not my question.
15 He's seen -- look, I'm not going to -- you've
16 objected.

17 Q. Doesn't it make it more important
18 for you, Doctor, to have an understanding that
19 this is accurate knowing that it's going to be
20 used for statistical analysis?

21 MS. HERMIZ: Objection to form.

22 A. Well, these two are different dates.
23 You're referring to a query that's run in 2016
24 and then queries that are run in --

25 Q. How do you get a query is run in

1 2016?

2 MS. HERMIZ: Objection to form.

3 A. The only differences are in these --
4 these -- so you're pointing out cases with
5 carfentanil differences for an undetected versus
6 carfentanil present.

7 Q. That's what my questions have been,
8 Doctor.

9 A. They're probably both true. There
10 was probably a drug screen done where none was
11 detected in our office and probably we did a
12 send-out to an office that had a methodology to
13 detect carfentanil at lower levels, and then the
14 send-out came back and then the database was
15 probably updated.

16 Q. Well, that might make sense if it
17 happened in that order, but the earlier printout
18 actually shows that it was detected and the
19 later one shows that it wasn't.

20 MS. HERMIZ: Objection to form.

21 A. Well, I did not perform this query
22 so --

23 Q. Doesn't it raise enough questions in
24 your mind that you want to understand it and
25 make sure that the details are correct, or do

1 you just not care and it's not your job?

2 MS. HERMIZ: Objection.

3 Counsel, I don't know how long
4 you're going to go around in circles.

5 MR. CHEFFO: We're not.

6 MS. HERMIZ: You are. There's no
7 foundation for him to answer any of these
8 questions. He's already said he's not
9 familiar --

10 MR. CHEFFO: He's a medical
11 professional. That's fine. Please just object.
12 I take your objection. That's fine.

13 Read my question back.

14 (Record read.)

15 MS. HERMIZ: Objection.

16 A. I can't explain these two apparent
17 discrepancies between these specific printouts.
18 I'm -- I didn't do these queries. I'm not the
19 individual who does the queries. I can't
20 resolve it here.

21 Q. My question is, do you have an
22 intention to look into this further, yes or no?

23 A. I don't have a specific intent to
24 look into it further at this time.

25 Q. Okay.

1 MR. CHEFFO: Let's take a short
2 break, please.

3 THE VIDEOGRAPHER: Off the record,
4 12:30.

5
6 (Luncheon recess taken.)

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1 THE VIDEOGRAPHER: We're back on the
2 record, 1:22.

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4 AFTERNOON SESSION

5 CONTINUED EXAMINATION OF GEORGE STERBENZ, M.D.
6 BY MR. CHEFFO:

7 Q. Doctor, I just had a question or two
8 about Exhibit 2. I'm on page 26. That may be
9 what we left off on, 55751, in the middle of the
10 page.

11 A. Which page?

12 Q. 25. I'm sorry. Maybe it's 26.
13 Sorry. 26.

14 Are you with me?

15 A. Yes.

16 Q. So 55751, on the cause of death it
17 says, "carfentanil toxicity," correct?

18 A. I'm sorry. Which case number?

19 Q. 55751, third from the bottom.

20 A. Yes.

21 Q. Carfentanil toxicity, correct?

22 A. Yes.

23 Q. And I'm actually -- you're welcome
24 to look at that other document, but -- I'm not
25 doing the cross-referencing thing, but you can

1 look. So my only questions are on 55751 as
2 they're on Exhibit 2 for right now.

3 Is -- the cause of death, that
4 determination is what's done to a reasonable
5 degree of medical certainty; is that right?

6 MS. HERMIZ: Objection to form.

7 Q. I'm actually only talking about
8 Exhibit 2.

9 A. I know you are.

10 Q. And I'm using it as an illustrative
11 example --

12 A. I know.

13 Q. -- okay.

14 A. Yes.

15 Q. And for reasons that we would --
16 strike that.

17 And as appears kind of, I think,
18 obvious, in 55751, the fact that oxycodone was
19 found in the toxicology results, that doesn't,
20 in and of itself, mean that oxycodone was a
21 cause of death in this case or in any potential
22 case, right?

23 MS. HERMIZ: Objection to form.

24 A. Yeah. It's -- I had become aware
25 that Exhibit 53 -- Exhibit 3 and Exhibit 2 are

1 different types of queries. Exhibit 2
2 references only blood. Exhibit 3 references
3 blood and then sometimes it references urine.

4 Q. And I don't think I asked you
5 anything about 3. I'll come back to that if
6 you --

7 A. But you did.

8 Q. No. Do you want me to read the
9 question back?

10 A. So these are different -- different
11 queries.

12 Q. Doctor, I don't think I asked you a
13 single question right now about 3.

14 A. I know.

15 Q. I'm talking about 2.

16 A. Okay. Read your question back.

17 Q. And I think that's why you're
18 smiling.

19 On Exhibit 2 -- so you can close
20 Exhibit 3. I have no questions about that.

21 A. Okay.

22 Q. I'm not going to ask you about
23 Exhibit 3.

24 A. Okay. Don't do it then.

25 Q. Okay. Exhibit 55751 on Exhibit 2 --

1 are you with me?

2 A. Yes.

3 Q. It says it's carfentanil toxicity as
4 the cause of death, right?

5 A. Yes.

6 Q. And that means that a determination
7 was made either by you or one of your colleagues
8 to a reasonable degree of medical certainty that
9 carfentanil toxicity was the cause of death,
10 right?

11 A. Yes.

12 Q. And with respect to oxycodone,
13 right, even though it was listed in the
14 toxicology results, a determination was made to
15 a reasonable degree of medical certainty that
16 oxycodone was not a cause of death; in fact, it
17 was carfentanil. Isn't that what Exhibit 2
18 says?

19 A. Okay. So this specific decedent,
20 55715, I don't have specific recall of her, and
21 I can't specifically recall if I was indeed the
22 pathologist who certified or the physician that
23 certified her death certificate. But to me what
24 this means is that, to a reasonable degree of
25 certainty, carfentanil is a fatal mechanism in

1 this specific decedent's death and that it
2 cannot be -- one cannot say to a reasonable
3 degree of certainty that oxycodone is a
4 mechanism in this individual's death. That's
5 not to say that it's impossible that the
6 oxycodone had a contributory -- or some type of
7 contribution, but it was determined at the time
8 of the certification that it could not be
9 contributed to a reasonable degree of certainty.

10 Q. Okay. And that's what I understood,
11 and I'm glad you clarified that. And that's why
12 I think you testified earlier that we can't just
13 kind of mechanically look at the tox results and
14 say that's the cause of death. There has to be
15 an analysis of the tox results, along with an
16 additional analysis by a professional like
17 yourself, to ultimately make the reasonable
18 degree of medical certainty as in all the
19 columns on Exhibit 2, right?

20 A. Exactly. And with this specific
21 individual, for example, when we co-reference
22 Exhibit 3, which has -- which doesn't reference
23 urine in this instance, I mean, blood, but urine
24 rather, the individual is also actively abusing
25 amphetamine, but amphetamine is not included in

1 the -- in the cause of death statement because
2 it was -- in this instance, it's a drug with a
3 comparatively short halflife that's only present
4 in urine, not present in blood, so it's
5 difficult to say, within a reasonable degree of
6 certainty, that mechanistically the amphetamine
7 was contributing to this individual's death. It
8 doesn't mean that the urine results are
9 incorrect and the blood results are more
10 correct. They're both correct. Just like with
11 Barbara Sands, has urine results and blood
12 results in two different exhibits. They're both
13 correct.

14 Q. Again, I'm referring to Exhibit 2.
15 You can answer it any way you need to. But my
16 question is -- I think we're on the same page on
17 this one -- is just the fact that a tox result
18 shows a particular chemical or drug doesn't
19 necessarily mean that it's the cause of death
20 and that requires an independent analysis by a
21 professional to make an overall determination as
22 to what the reasonable degree of the cause of
23 death was.

24 Do you understand my question? I
25 can rephrase it if you need me to.

1 Do you understand my question or
2 not?

3 A. Your question was somewhat garbled
4 and circular.

5 Q. That's why I asked you -- if it's
6 garbled, all you need to do, Doctor, is say "I
7 don't understand it" and I will be more than
8 happy to repeat it, which I'm going to do right
9 now. Okay. None of us want you to guess, and
10 if my questions are so garbled or muddy or
11 cloudy, you just tell me that and I'll rephrase
12 it. Okay?

13 Just because something is listed in
14 a toxicology result does not mean mechanically
15 that it's the cause of death; in order to
16 determine cause of death, a medical examiner has
17 to look at the totality of the circumstances and
18 form an independent judgment based on the -- to
19 a reasonable degree of certainty, based on all
20 of the facts; isn't that right?

21 A. It's correct that the -- the
22 pertinent findings of the case, the pertinent
23 facts of the case need to be considered rather
24 than just reflexively looking at a single test
25 and making it a blatant or a reflexive policy

1 decision based upon a single test that a
2 certification will be -- now I'm rambling.

3 Just because a drug is present on a
4 drug screen doesn't mean it will automatically
5 be represented in the cause of death statement.
6 The case does need to be examined for all
7 pertinent facts.

8 Q. So I'll take that as a yes, but let
9 me ask you another question, and I'm going to
10 move off of this for a minute.

11 Is Dr. Kohler a good medical
12 examiner?

13 MS. HERMIZ: Objection to form.

14 A. Yes.

15 Q. Do you trust her judgment?

16 A. I do.

17 Q. Do you think she has integrity?

18 A. Yes.

19 Q. Do you think she's skilled and
20 capable at her job?

21 A. Yes.

22 Q. Do you believe that the department
23 currently has the resources to do the job that
24 the county executive and the public expects of
25 it?

1 MS. HERMIZ: Objection to form.

2 A. We're short-staffed currently.

3 Q. Are you able to function and --
4 excuse me. Strike that.

5 Are you able to perform the
6 functions that you think are necessary for your
7 department?

8 MS. HERMIZ: Objection to form.

9 A. We are short-staffed currently. If
10 we are going to be able to continue providing
11 the service that -- within the statutes of the
12 State of Ohio that the medical examiner's office
13 needs to fulfill, we will need to be fully
14 staffed at some point in the near future.

15 Q. Up to this point, have you, in your
16 view, complied with all of the obligations that
17 the statutes of Ohio require you to do?

18 MS. HERMIZ: Objection to form.

19 A. I believe -- I believe we have, yes.

20 Q. And that's as far back as you can
21 remember; is that right?

22 A. Yes.

23 Q. There's never been a time where you
24 don't think you've had adequate funding or
25 staffing to do the job and the functions that's

1 required of you by the state; isn't that fair?

2 MS. HERMIZ: Objection to form.

3 A. We periodically go through periods
4 of being short-staffed when individuals leave,
5 which makes it more difficult to carry out
6 our -- our duties. But I -- I believe we have
7 always fulfilled our statutory duties.

8 Q. Has there ever been a time where you
9 have gone to a superior or anyone and said you
10 are unable to fulfill your statutory duties to
11 the citizens of Summit County because of funding
12 or some other constraints?

13 A. No.

14 Q. And I take it if you believed that,
15 you would have voiced that concern; is that
16 right?

17 MS. HERMIZ: Objection to form.

18 A. Maybe.

19 Q. So you think that it's possible that
20 if you believed you were deficient as a
21 department in performing your duties and
22 obligations to the citizens, that you might tell
23 somebody about that?

24 MS. HERMIZ: Objection to form.

25 A. I believe your initial question was

1 regarding funding.

2 Q. Sure. You can -- so if -- aren't
3 they tied together?

4 A. Well, I believe your initial
5 question was if I believed that the -- that the
6 office wasn't adequately funded, is what was my
7 impression that you were asking, that I would go
8 to some -- a superior to state that we were --
9 it was my -- that it's my opinion that the
10 office is inadequately funded to fulfill the
11 duties of the office.

12 Q. I don't think I asked that, but if I
13 did, I apologize. That wasn't my question I
14 meant. Let me just ask you, if you believed
15 that, for whatever reason, funding or something
16 else, that you or the people in your department
17 were unable to perform the core duties and the
18 required duties of the department, is there any
19 question in your mind that you would raise that
20 concern with your superiors and/or others?

21 MS. HERMIZ: Objection to form.

22 A. If I believed I was unable to carry
23 out my duties in the office, I would raise my
24 concerns with Dr. Kohler.

25 Q. And have you ever done that?

1 A. There have been times when we were
2 short-staffed and I presented my concerns
3 regarding time management to Dr. Kohler.

4 Q. And in presenting that to
5 Dr. Kohler, was there ever a time where you told
6 her that you were unable to perform the duties
7 that were required of you and, in fact, you
8 didn't perform those?

9 MS. HERMIZ: Objection to form.

10 A. No. I have always performed my
11 required duties.

12 Q. And do you believe the same is true
13 for your department?

14 MS. HERMIZ: Objection to form.

15 A. Yes.

16 Q. At all times that you've been there,
17 right?

18 A. I do. I believe that's true.

19 Q. Have you ever diagnosed a decedent
20 with -- with addiction?

21 A. Addiction is a clinical diagnosis,
22 so that's not a diagnosis that I would make;
23 therefore, I've never listed the term
24 "addiction" on -- on an autopsy report. I would
25 use the term a chronic drug abuse or acute drug

1 abuse or chronic active drug abuse.

2 Q. I thought you told me earlier that
3 you actually had some experience or expertise
4 with addiction.

5 MS. HERMIZ: Objection to form.

6 A. Insofar as it involves the work that
7 I do at the medical examiner's office, I do.
8 The individuals which I am classifying as
9 chronic drug abuse would have a clinical
10 correlate of drug addiction in most instances.

11 Q. So they're basically the same thing?

12 MS. HERMIZ: Objection to form.

13 A. Well, it's very similar. It's a
14 similar thing.

15 Q. So you may not have diagnosed them
16 with addiction --

17 A. For example, pulmonary emphysema is
18 a similar thing to chronic obstructive pulmonary
19 disease, but pulmonary emphysema is the anatomic
20 manifestation of a clinical disease, which is
21 chronic obstructive pulmonary disease, or
22 something like congestive heart failure is a
23 clinical classification, whereas ischemic
24 cardiomyopathy is -- or ischemic dilated
25 congestive cardiomyopathy is an anatomic

1 manifestation of that clinical classification.

2 Q. So is drug abuse the anatomical
3 manifestation of addiction?

4 A. It's the term most commonly used by
5 forensic pathologists for -- with regards to
6 death classification.

7 Q. Do you have any -- do you know what
8 the DSM is?

9 A. No.

10 Q. You've not heard of the DSM-4,
11 DSM-5?

12 A. I've heard of DSM, of course, but I
13 don't know what that specific DSM is. It's
14 not -- DSM, once again, is a clinical form of
15 classification and it doesn't apply to the
16 practice of forensic pathology directly.

17 Q. To the extent that drug abuse is the
18 physical manifestation, according to your
19 testimony, of addiction, wouldn't you want to
20 know how addiction is defined?

21 MS. HERMIZ: Objection to form.

22 A. Clinical classifications are used
23 for issues such as prognosis and treatment, and
24 when -- with regards to my patients, with regard
25 to individuals that come to the medical

1 examiner's office, there is no treatment and
2 their prognosis is grim, they're dead, so a
3 classification system like a DSM does not apply.

4 Q. So what -- are there any criteria to
5 determine or to benchmark how you would
6 determine that someone is or was a drug abuser?

7 A. Yes. Through the investigation and
8 through the autopsy examination, I can establish
9 a reasonable degree of certainty to indicate
10 that an individual has acute drug abuse, chronic
11 drug abuse or acute and chronic active drug
12 abuse or acute and chronic drug abuse.

13 Q. And I guess I'm just trying to
14 understand -- and the answer may be no and it
15 may be yes. I just don't know, Doctor. I'm
16 just trying to understand if there's any
17 objective criteria or guidelines that you call
18 upon or use in your professional capacity that
19 outline the methodology or the criteria to
20 determine whether someone is or is not a drug
21 abuser.

22 A. Are you referring to established
23 diagnostic criteria for forensic pathologists?

24 Q. Yes. That's why I referenced the
25 DSM. So, in other words, if you wanted to

1 know -- I think it's to your point earlier -- I
2 don't want to give a speech, but you took issue
3 a little bit with the epidemiology or epidemic
4 because there are certain criteria, right?

5 There are -- people may say I'm addicted to this
6 or addicted to that, but there are defined terms
7 and characteristics, right, in the DSM and
8 others, as I understand it, that talk about
9 addiction, okay. And all I'm trying to find out
10 is whether there are such defined terms or
11 characteristics outlined somewhere that talk
12 about drug abuse that you rely on in making a
13 determination of drug abuse.

14 A. There's no such diagnostic criteria
15 as would be presented by a DSM type of
16 diagnostic format.

17 Q. So there's -- there's probably some
18 overlap in factors that certain medical
19 examiners would use here and across the country,
20 but there's no kind of objective criteria that
21 you're talking about that would kind of define
22 what someone should or should not look for to
23 determine whether someone is a drug abuser; is
24 that fair?

25 MS. HERMIZ: Objection to form.

1 A. Well, let's recognize that for the
2 vast majority of individuals that are listed
3 with drug abuse issues, they are active drug
4 abusers. The criteria is going to be their
5 active drug use. But there is no DSM style
6 diagnostic criteria scheme to follow.

7 Q. And as you sit here today, you're
8 not familiar with what the DSM criteria are for
9 addiction; is that right?

10 A. I mean, that's not to say I've never
11 reviewed the DSM, but I know I'm not so familiar
12 that I can testify as to the content of the DSM.

13 Q. Would you have reviewed the DSM in
14 connection with your professional work?

15 MS. HERMIZ: Objection to form.

16 A. No. I would have reviewed the DSM
17 in conjunction with my medical school education.

18 Q. Right. Because you just told us
19 that's clinical and you're not clinical, right?

20 A. I'm not making a clinical assessment
21 of the individuals because they're beyond that
22 point.

23 Q. So the last time you would have
24 reviewed the DSM would have been 30 years ago?

25 A. The last time I would have tried to

1 attempt to memorize the DSM was when I was in
2 medical school, close to 30 years ago, yes.

3 Q. Do people memorize -- let me strike
4 that. When was the last time that you looked at
5 the DSM for professional purposes?

6 A. Are you referring to the DSM --
7 well, it used to be in a book. Itself, I
8 haven't reviewed the DSM book itself in years.
9 The only -- my only connection to the DSM
10 classifications would be in decedents' medical
11 records at this point in my career.

12 Q. So isn't the answer that you don't
13 regularly look at the DSM because it's not part
14 of what you need to do?

15 A. That's true, I don't. It's not part
16 of what I need to regularly do.

17 Q. Now, under your classification, how
18 long does someone need to be abusing a substance
19 in order to have a drug abuse disorder?

20 MS. HERMIZ: Objection to form.

21 A. I don't diagnose people with drug
22 abuse disorder. I'm going to classify them as
23 acute drug abuse, chronic drug abuse, or acute
24 and chronic drug abuse, but that's -- it's not a
25 DSM style of diagnosis, like drug abuse

1 disorder.

2 Q. What's acute -- give us some
3 parameters -- and what's chronic?

4 A. Acute would be, for example,
5 individuals that are deceased with acute drug
6 toxicities. That's an acute drug abuse episode.
7 A chronic drug abuse would be an individual
8 who's been abusing substances in the past and
9 are perhaps presenting with physical stigmata of
10 chronic drug abuse, such as, for example, liver
11 disease in chronic alcoholics, or lung disease
12 in people that are smoking crack cocaine or
13 smoking methamphetamine.

14 Q. So acute could be a one-time use?

15 A. Acute drug abuse, in theory, could
16 be one-time use, yes.

17 Q. So if someone was the first time --
18 strike that.

19 If someone used a drug for the first
20 time and, unfortunately, died, they would be an
21 acute drug user, or drug abuser?

22 A. No, not exactly.

23 Q. Well, how would you know?

24 A. I wouldn't classify them as an acute
25 drug abuser. They would be classified as having

1 died of acute drug abuse if it was determined by
2 the course of the investigation that they were
3 using a drug illicitly for recreational
4 purposes.

5 Q. So what would be an acute drug
6 abuser?

7 A. Well, I wouldn't classify someone as
8 an acute drug abuser. I would classify someone
9 as -- their acute drug toxicity as acute drug
10 abuse.

11 Q. Okay. So then the only
12 characterization for drug abuser is chronic?

13 MS. HERMIZ: Objection to form.

14 Q. Because I thought you told me that
15 there was acute. I mean, I wrote these down,
16 Doctor. I'm just trying to follow your
17 testimony. Acute and chronic you told me for
18 drug abuser. Maybe I misunderstood. Is there
19 such a thing --

20 A. So, by history, we -- there could be
21 clinical or anecdotal history that an individual
22 is a chronic or acute -- is a drug abuser.
23 You're referring to a DSM style of --

24 Q. Doctor, just so we don't get too far
25 afield, I'm really just talking about -- we

1 talked about DSM. I'm not talking about that
2 anymore. I'm just trying to understand, if I
3 was to look at your records and see drug abuser,
4 how it would be defined, right. So, in your
5 mind, if someone was -- because you told me you
6 don't diagnose people with addiction, but you
7 would label them, as part of your professional
8 duties, as a drug abuser. Is that right?

9 A. I wouldn't use the term "drug
10 abuser" with e-r at the end. I would classify
11 them as acute drug abuse, chronic drug abuse, or
12 a combination of acute and chronic drug abuse.

13 Q. So acute drug abuse by a decedent
14 would be what?

15 MS. HERMIZ: Objection to form.

16 A. As I previously stated, individuals,
17 for example, who are dying of acute drug
18 toxicity can be classified under acute drug
19 abuse.

20 Q. And is there any -- is that done by
21 the number of times? So, in other words, if
22 someone was to use a methamphetamine
23 recreational, once or two times, would that be
24 acute drug abuse?

25 A. Okay. So all of my patients are

1 dead.

2 Q. We got that.

3 A. But just to clarify that. They're
4 all dead. So if someone dies with an acute
5 cocaine intoxication or acute cocaine toxicity,
6 for example, that is, by definition, acute drug
7 abuse because they died from an acute
8 intoxication. That same person might be a
9 chronic drug -- cocaine abuser, and part of
10 their chronic disease, they might have developed
11 cardiovascular manifestations of their cocaine
12 use. They might have cocaine-induced changes of
13 their coronary arteries, for example. They
14 might have visceral infarcts, for example, from
15 prior, but more remote, cocaine use. So that
16 same -- so that individual, now with evidence of
17 prior abuse of cocaine, who is now dying of an
18 acute cocaine toxicity, is dying -- can be
19 classified as chronic active drug abuse, or one
20 could also say acute and chronic drug abuse.

21 Q. So I think I understand. So is it
22 fair to say, then, that because you don't have a
23 crystal ball, you can't know what happened to
24 someone during their lifetime; what you can do
25 is try and determine if there are sequelae of

1 their conduct while they were alive that gives
2 you insight as to how their drug abuse or drug
3 use may have impacted their death?

4 These are not trick questions. I
5 can read them back if you want me to.

6 A. Yeah. Can you repeat that?

7 MR. CHEFFO: Can you please read
8 that?

9 (Record read.)

10 A. Okay. Everything that I do is
11 directed towards establishing cause and manner
12 of death. During the course of that
13 investigation, I will, for example, be able to
14 establish, in many individuals who are dying of
15 drug overdoses, that they have prior history of
16 drug abuse. That can come from medical records.
17 That can come from next of kin. That can come
18 from anatomic stigmata of chronic drug abuse.
19 What I'm really interested in is their cause and
20 manner of death, and if that individual is dying
21 of an acute drug toxicity, that's what --
22 obviously, that's what I'm mostly concerned
23 about for establishing cause and manner of
24 death. I'm not going to ignore all the other
25 information, and I will appropriately list it in

1 a list of -- diagnostic list on the autopsy
2 report.

3 Should I not be able to interview
4 family, because family cannot be found, should I
5 not be able to obtain medical records because I
6 do not know who that individual's doctor is, or
7 maybe they never had a doctor, and should that
8 individual never -- doesn't have well-defined
9 stigmata of chronic drug abuse, that still
10 doesn't prevent me from certifying their death
11 certificate to a reasonable degree of certainty
12 as an acute drug toxicity, and the fact that I
13 might not be able to elucidate their history
14 doesn't prevent me from certifying their cause
15 of death, and it's not -- because it's not
16 necessary in some instances.

17 Q. You don't make clinical
18 determinations about whether someone was
19 addicted or a drug abuser during their lifetime,
20 right; that's not within your purview?

21 A. The term "clinical determination,"
22 that's -- you're talking about living people, so
23 I do not examine living people and treat living
24 people and make determinations that living
25 people have a drug addiction problem, because I

1 don't have a clinical practice, I'm not
2 practicing clinical drug addiction medicine.

3 Q. So if someone comes into your --
4 into the medical examiner's office, you may note
5 drug abuse as part of --

6 A. You mean a decedent?

7 Q. When a decedent comes in --

8 A. Yeah.

9 Q. -- you may note drug abuse, but do
10 you make a determination that they were a drug
11 abuser when they were living or that they were
12 addicted when they were living? Is that a
13 diagnosis that you make?

14 MS. HERMIZ: Objection to form.

15 A. If I'm told they had a history of
16 prior drug abuse, I can include that in my
17 diagnostic list. If I find physical
18 manifestations of prior drug abuse, I can
19 include that in my diagnostic list.

20 Q. You don't independently make a
21 determination -- let's just stick with
22 addiction. Do you ever make a determination
23 that a decedent was addicted to a particular
24 substance?

25 A. All of my patients are not addicted

1 anymore. They're all dead. So the very
2 question that you're posing is really a clinical
3 question for people that are alive. None of my
4 patients are addicted anymore because they're
5 dead.

6 Q. Thank you for that clarification.
7 Do you make a determination that a
8 decedent, when he or she was alive, was
9 addicted?

10 MS. HERMIZ: Objection to form.

11 Q. Do you look back prior to their
12 death and make a determination as to whether
13 they were addicted or not? This is a pretty
14 simple question.

15 A. Your question is using terminology
16 that applies to living people.

17 Q. That's right. Isn't the answer,
18 Doctor, that you don't make determinations as to
19 living people when they're alive? Isn't that
20 what you've just been telling me, and I've just
21 been trying to put a finer point on it so I can
22 understand it?

23 A. I can make a -- I will do a
24 classification of acute -- of chronic drug
25 abuse, for example. The presumption is that if

1 this individual had chronic drug abuse, that
2 they were addicted -- they possibly had an
3 addiction to their -- to that substance. But
4 even the term "addiction" has different clinical
5 implications, as opposed, you know -- you know,
6 I'm sitting here, I'm thinking addiction is
7 meaning a physiologic dependence upon a
8 substance; that if that individual stops using
9 that substance, they can have bad physiologic
10 withdrawal responses. And -- so I -- I can't
11 presume to make clinical diagnoses, but on the
12 other hand, sometimes the -- the history and the
13 physical stigmata imply a clinical situation.
14 Sometimes anatomy can imply a potential
15 operation in physiology.

16 So that, for example, with people
17 that are addicted to alcohol, many of these
18 people die during the course of alcohol
19 withdrawal. Well, they come to me dead.
20 They're not withdrawing from anything at the
21 time when they come to me. But I can -- during
22 the course of my examination, I can say it is
23 reasonable to conclude based upon, at the end of
24 my total investigation, that this person
25 probably died due to complications of their

1 chronic alcoholism and as might be related to
2 alcohol withdrawal due to being addicted to
3 alcohol. I'm not making -- really making a
4 diagnosis that -- of addiction per se, but I'm
5 implying that the post-mortem findings are
6 implying -- the history and the anatomy is
7 implying something more clinical, implying
8 something more physiologic.

9 Q. Do you have any role in the budget
10 for the department, the medical examiner's
11 department?

12 A. I think my role in the budget is my
13 salary.

14 Q. You don't do any projections or
15 submissions to the county executive? Is that
16 within Dr. Kohler's ambit of responsibilities?

17 A. I don't do budget projections. I
18 assume Dr. Kohler is involved with that to some
19 extent. Exactly how she's involved, I don't
20 know.

21 Q. There's an annual report that is
22 done. It seems to be lagging a few years, but
23 it's done with some level of frequency. Are you
24 familiar with that annual report? Are you
25 familiar with it?

1 A. Are you talking with regards to the
2 annual statistics?

3 Q. Yes. I'll show it to you. It's the
4 one that says "Annual Report" on it and has the
5 statistics.

6 Are there more than one annual
7 report?

8 A. I don't know.

9 Q. Wouldn't you know?

10 MS. HERMIZ: Objection to form.

11 A. Not necessarily.

12 Q. Really? Okay.

13 MR. CHEFFO: Let's mark this,
14 please.

15 THE VIDEOGRAPHER: May I change
16 video?

17 MR. CHEFFO: Sure.

18 THE VIDEOGRAPHER: We're off the
19 record at 2:02.

20 (Short recess had.)

21 THE VIDEOGRAPHER: We're back on the
22 record, 2:04.

23 - - - - -

24 (Thereupon, Deposition Exhibit 4,
25 2016 Summit County Medical Examiner

1 Annual Report Beginning Bates Number
2 SUMMIT_000022367, was marked for
3 purposes of identification.)

4 - - - - -

5 Q. I've put before you Exhibit 4,
6 Doctor. Have you ever seen this document
7 before?

8 A. Yes.

9 Q. What is it?

10 A. This is the statistical report
11 that's generated by the Summit County Medical
12 Examiner's Office. This one is specifically for
13 the year 2016.

14 Q. Are you aware of any annual reports
15 that are prepared by the Summit County Medical
16 Examiners other than this one?

17 A. It's my understanding an annual
18 report is generated, which means every year.

19 Q. No. Is this the only type of report
20 that's generated, or are there others?

21 MS. HERMIZ: Objection to form.

22 A. This is the only -- so this is the
23 only statistical report I'm aware of that's
24 generated by the office.

25 Q. Are you aware --

1 A. I think queries are run for various
2 agencies if -- when requested, but I'm not
3 part -- involved in that.

4 Q. What's your role in connection with
5 this annual report?

6 A. My role is that I'm performing some
7 of the autopsies and death certifications that
8 are being used to generate these statistics.

9 Q. Do you have any input into this
10 report?

11 A. No.

12 Q. Do you review it before it goes out?

13 A. No.

14 Q. Have you ever reviewed it before,
15 either the 2016 or prior?

16 A. Reviewed it in what sense? I mean,
17 right now you could say I'm reviewing it. Do
18 you mean like this?

19 Q. No. I don't mean flipping through
20 it. I mean, you know, taking any time to go
21 through it, either for accuracy or for general
22 interest.

23 A. I can say that I have definitely not
24 reviewed it for accuracy, and I don't recall
25 spending time with the 2016 stat report,

1 reviewing it previously, other than just
2 basically what you see me doing here, just kind
3 of looking through it quickly.

4 Q. Okay. And other than the fact,
5 right, that the work you have done on some
6 granular level may get caught up in the
7 statistics, have you actually done independent
8 work to compile data or statistics specifically
9 for the purpose of putting it into this report?

10 A. No. That's not part of my function
11 at the office.

12 Q. And your name is on the second page?

13 A. Yes.

14 Q. Did you know that?

15 A. I do now.

16 Q. Page 18, please. This has a heading
17 of -- actually, the page before -- excuse me --
18 it's unpaginated. I guess it -- it's before 17.
19 It says, "Toxicological Studies." I'm just
20 trying to orient you to the section. And then
21 17 says, "Statistics Report," and then 18 has
22 some statistics data in bar charts.

23 Do you see that?

24 A. Yes.

25 Q. If you need to, though I suspect

1 you're relatively familiar with it, there's a
2 number of entries in 2016 in that Exhibit 2 that
3 we've been looking at that talk about deaths
4 associated with methamphetamines.

5 MS. HERMIZ: Objection to form.

6 A. I don't know what -- what are you
7 specifically referring to?

8 Q. If you need to go through it, you
9 can, but like the very first one that we've
10 talked about, 1-1-2016, do you see that?

11 A. Case number 55236?

12 Q. Right.

13 What's the cause of death?

14 A. "Combined methamphetamine and
15 fentanyl toxicity."

16 Q. Down below, 55240, what does that
17 one say?

18 A. "Combined fentanyl/methamphetamine
19 toxicity/overdose."

20 Q. And we can -- you can flip to the
21 next page, 55244, "Combined fentanyl and
22 methamphetamine toxicity." Do you see that?

23 A. Yes.

24 Q. 55247, "acute mixed methamphetamine
25 and ethanol toxicity," do you see that?

1 A. Yes.

2 Q. 55257, "methamphetamine toxicity,"
3 do you see that?

4 A. Yes.

5 Q. You're welcome to flip through this,
6 but there are other examples of methamphetamine
7 toxicity in the report?

8 A. Yes.

9 Q. So my question is, where on page 18
10 is or are methamphetamine deaths reflected?

11 MS. HERMIZ: Objection to form.

12 A. Well, there's two figures on page
13 18. Figure 20 is headed, "Reflects the number
14 of most commonly found drugs that were not
15 necessarily the cause of death but were found in
16 a routine drug screen." And the drugs that
17 were -- are listed in figure 20 are carfentanil,
18 citalopram, cocaine, fentanyl, heroin,
19 hydrocodone, methadone, morphine and oxycodone;
20 therefore, that would imply, then, that
21 methamphetamine was not one of the most commonly
22 found drugs that were not necessarily the cause
23 of death but were found in a routine drug
24 screen.

25 Figure 21 states that it reflects

1 the number of most commonly found drugs that
2 were determined to be the cause of death," and
3 those are listed as carfentanil, citalopram,
4 cocaine, fentanyl, heroin, hydrocodone,
5 methadone, morphine and oxycodone, and
6 methamphetamine is not included in that -- that
7 list of one, two, three, four, five, six, seven,
8 eight, nine; nine drugs.

9 Q. We know figure 21 is not accurate
10 based on Exhibit 2, right?

11 MS. HERMIZ: Objection to form.

12 A. I don't know that to be true.

13 Q. Well, it says, "Drugs most commonly
14 found as the cause of death." Do you see that?

15 A. Yes.

16 Q. And it lists -- let's look at
17 hydrocodone. How many numbers of hydrocodone
18 deaths?

19 A. Two.

20 Q. Well, we only need to go probably
21 two or three pages into this. Look at 55236,
22 right. Then look at the ones we just talked
23 about, 55240, 55257, 55247, 55244. We're
24 already above two, aren't we?

25 MS. HERMIZ: Objection to form.

1 A. From this query, yes.

2 Q. So how can it be that the internal
3 query of the documents showing cause of death
4 has many, many more than two in terms of
5 methamphetamine deaths but it doesn't show up on
6 the chart?

7 A. I did not participate in the
8 generation of these statistics, so I don't -- I
9 don't know why it's not there or --

10 Q. I think you just explained this
11 chart says it reflects the number of most
12 commonly found drugs that were determined to be
13 the cause of death, right? That's what figure
14 21 purports to do, right?

15 A. That's what it states in the
16 heading, yes.

17 Q. Would you agree with me that
18 methamphetamines were found to be the cause of
19 death in at least more than two? And we could
20 probably go through it and find 20, 30, 40.

21 MS. HERMIZ: Objection to form.

22 A. I can't -- I can't -- I can't
23 explain the query and I can't explain the chart
24 in the report.

25 Q. And you've testified you did not

1 personally perform or create this chart. I
2 understand that. And I'm just asking you just
3 some fact-based questions, and you'll tell me as
4 honestly as you can.

5 Would you agree with me that there
6 are more incidences where the cause of death by
7 the medical examiner's office in 2016 attributes
8 methamphetamines as the cause of death than
9 several of these other drugs or chemicals?

10 MS. HERMIZ: Objection to form.

11 A. I don't know enough about the
12 criteria that was used to generate the bar
13 graphs on page 18 to provide testimony about
14 them.

15 Q. Okay. Well, let me -- this is for
16 the general public, isn't it?

17 A. I think it's accessible by the
18 general public, yes.

19 Q. I'll represent to you, it's on the
20 website.

21 A. Okay.

22 Q. So putting aside -- and I know you
23 will tell me that you didn't make this document,
24 you didn't put the chart together, but what do
25 you think figure 21 is supposed to represent?

1 What is it supposed to tell the reader?

2 MS. HERMIZ: Objection to form.

3 A. I can state what it says on the bar
4 graph.

5 Q. You, as a citizen, what do you think
6 that it's trying to represent?

7 MS. HERMIZ: Same objection.

8 A. I can only state what it says on the
9 bar graph, which I've already read.

10 Q. Which is this is supposed to tell
11 people the most commonly found causes of
12 death -- the drugs that are most commonly found
13 as the cause of death in 2016, right?

14 A. That's what it says, yes.

15 Wait. Yes.

16 Q. And you've now seen, which we spent
17 a fair amount of time on Exhibit 2, the data
18 from your department that was produced, right?

19 MS. HERMIZ: Objection to form.

20 A. I was not involved in this query.

21 Q. Do you have any reason to believe
22 that's inaccurate? Is there anything that
23 you've seen today that shows you that it's not
24 accurate or didn't come from your office?

25 MS. HERMIZ: Objection to form.

1 A. All I can say is I was not involved
2 in this query. I can't say it's accurate or
3 inaccurate.

4 Q. If you assume it was produced in
5 connection with the litigation by your office,
6 would you expect it to be accurate or
7 inaccurate?

8 MS. HERMIZ: Same objection.

9 A. I can't testify to the accuracy of
10 Exhibit 2. I was not involved in producing
11 Exhibit 2.

12 Q. Should the public be able to rely on
13 this annual report, Exhibit 4?

14 MS. HERMIZ: Objection to form.

15 A. I was not involved in the production
16 of the annual report for 2016.

17 Q. I understand that, Doctor, but do
18 you ever go on to a government website ever, not
19 the Summit County but just a government website?
20 Do you?

21 A. I have, yes.

22 Q. Do you have an expectation that you
23 should be able to rely on the information?

24 MS. HERMIZ: Objection to form.

25 A. I assume so, yes.

1 Q. And wouldn't you assume that the
2 citizens of Summit County, if they flip on your
3 website and read figure 20 or 21, that they
4 should have an assumption that it's accurate?

5 MS. HERMIZ: Same objection.

6 A. I would assume so, yes.

7 Q. And wouldn't you assume that
8 there's -- there's also reporting that's done,
9 both from a state level and probably federal
10 level, based on your details and statistics from
11 your office?

12 MS. HERMIZ: Objection to form.

13 A. The office is not my personal
14 office. I am an employee at the office. But,
15 once again, I -- I was not involved in the
16 production of the -- the figures on page 18, and
17 I can't testify that they're inaccurate or
18 accurate.

19 Q. Even though you've just seen -- for
20 three hours, we've looked at all this data that
21 clearly shows that the cause of death listed is
22 methamphetamine, and it's more than many of
23 these entries, you're not willing to say that
24 there's an inaccuracy here?

25 MS. HERMIZ: Objection to form.

1 A. That's correct.

2 Q. Are you willing to say it's at
3 least --

4 A. I don't know enough about these two
5 figures on page 18 to say they're accurate or
6 inaccurate.

7 Q. Do you know any more than any
8 citizen would take away from this?

9 MS. HERMIZ: Objection to form.

10 A. I'm not even sure what you're
11 asking.

12 Q. This is supposed to tell people in
13 the public and others data and information,
14 right? That's what figures 20 and 21 are
15 supposed to do, right?

16 A. Yes.

17 Q. And it's supposed to be accurate,
18 isn't it?

19 A. Yes.

20 Q. Because if it's inaccurate, it could
21 get reported and that could lead to further
22 inaccurate results if they're aggregated,
23 correct?

24 A. Yes.

25 Q. And you have professional pride in

1 your job, don't you?

2 A. Yes.

3 Q. And you have professional pride and
4 integrity in your department, whether or not you
5 personally did something or whether your
6 colleagues did it, right? Don't you take pride
7 in what your office does?

8 A. I do.

9 Q. Right.

10 And if you looked at something and
11 you saw it was just clearly wrong, wouldn't you
12 want to understand why that's the case?

13 MS. HERMIZ: Objection to form.

14 A. I cannot testify that the
15 information in -- on page 18 of the 2016 annual
16 report is wrong.

17 Q. Can you explain why there's no
18 reference to methamphetamine when you know,
19 because you're one of the medical examiners,
20 that you've made a determination that the cause
21 of death in multiple cases is higher than what's
22 listed on this chart?

23 MS. HERMIZ: Objection to form.

24 A. You're making a comparison between
25 an exhibit, a statistical exhibit, which I was

1 not involved in its -- directly involved in its
2 production, and a database query, which I was
3 not directly involved with producing the query.
4 So I cannot compare the two. I cannot provide
5 testimony regarding the comparison of these two
6 exhibits.

7 Q. Let me ask you -- put that aside
8 then.

9 Can you tell us, in 2016 are you
10 aware of one death that you worked on that the
11 cause of death was methamphetamine? Can you
12 remember one case?

13 A. I don't have immediate recall of the
14 causes of death for 2016.

15 Q. One case.

16 A. I would like to say that I
17 remember -- have immediate recall of all of my
18 deaths that I have performed investigations on,
19 but I don't have a specific recall for 20 -- for
20 the year 2016.

21 Q. Can you remember one that the cause
22 of death was methamphetamine?

23 MS. HERMIZ: Objection to form.
24 Asked and answered.

25 A. I can't answer it any better than I

1 already have.

2 Q. And if you look through Exhibit 3,
3 and you can take the time to look through
4 Exhibit 3, that wouldn't refresh your
5 recollection that one of those -- one of those
6 cases worked on was yours?

7 MS. HERMIZ: Same objection.

8 Q. Let me ask you a different question.
9 I mean, looking at this, how many people in 2016
10 did autopsies?

11 A. Other than myself? The majority of
12 the autopsies in 2016 were performed by myself
13 and Dr. Kohler.

14 Q. And what percentage, roughly, do you
15 think you did?

16 A. What percentage? Many of the
17 autopsies. The exact percent, I don't know.

18 Q. 50 percent, if not more?

19 MS. HERMIZ: Objection to form.

20 A. Something like that.

21 Q. And if I represented to you, and you
22 can look at it, that 39 of the causes of death
23 in 2016 list methamphetamine -- you're a
24 statistics person, right? You like hard data?

25 MS. HERMIZ: Objection to form.

1 A. I don't think that's a question.

2 Q. It is. Do you believe in
3 statistics?

4 MS. HERMIZ: Objection to form.

5 A. I do recognize statistics, yes.

6 Q. So do you think of the 39 causes of
7 death that list methamphetamine, based on the
8 fact that you did 50 percent or so of the
9 autopsies, that one of them was performed by
10 you?

11 MS. HERMIZ: Objection to form.

12 A. I can't -- I don't have immediate
13 recall so I cannot offer testimony as to the
14 number of deaths that I -- for the death
15 investigations that I performed in 2016 were --
16 which number were methamphetamine fatalities.

17 Q. Whether they were yours or somebody
18 else, can you explain why, even though there's
19 39 listed as the cause of death, not one of them
20 made it onto figures 20 or 21?

21 MS. HERMIZ: Asked and answered.

22 A. I was not involved in the
23 statistical figures shown in page 18 of the 2016
24 annual report. I did not -- I was not involved
25 in the query that's Exhibit 2, and I cannot

1 offer testimony for the comparison between the
2 two exhibits.

3 Q. When you go back to the office
4 tomorrow, are you going to ask and look into why
5 there's this discrepancy?

6 MS. HERMIZ: Objection to form.

7 A. I can't -- I can't state that there
8 is indeed a discrepancy or some type of
9 discrepancy, and I was not involved in this
10 query.

11 Q. That's not my question. My question
12 was, are you going to go back -- are you going
13 to go in the office tomorrow and ask if there's
14 a discrepancy and, if so, how are you going to
15 fix it? It's a yes or no question.

16 A. I do not have plans to do that at
17 this time.

18 Q. What would it take for you to ask
19 somebody if there was a mistake in documents
20 when you believe that there was?

21 MS. HERMIZ: Objection to form.
22 Argumentative.

23 A. Repeat your question.

24 Q. Sure.

25 What would prompt you to ask one of

1 your colleagues or supervisor if there was a
2 mistake in publicly available documents?

3 MS. HERMIZ: Same objection.

4 A. I don't even know how to answer
5 that. I don't have -- I don't have a response.

6 Q. You can't think of any situation
7 where you would ask somebody if there was a
8 mistake?

9 A. Not right now.

10 Q. Is part of your job to give the
11 public accurate information?

12 MS. HERMIZ: Objection to form.

13 A. I am not directly involved in the
14 statistical annual report, so it is not part of
15 my responsibilities for verifying the accuracy
16 of the statistical annual report. I do perform
17 death investigations, and the content or the
18 accuracy of my death certifications need to be
19 within a reasonable degree of certainty, and I
20 believe that I've always performed death
21 certifications to within a reasonable degree of
22 certainty.

23 Q. You view your job just regarding
24 death investigations and you don't believe you
25 have any responsibility for the public

1 perception of data that's generated by your
2 department? Is that your testimony?

3 MS. HERMIZ: Objection to form.

4 A. I don't participate directly in the
5 statistics generated by the office that are
6 compiled in the annual report.

7 Q. Do you care if they're accurate?

8 MS. HERMIZ: Objection to form.

9 A. I don't have a response to that at
10 this time.

11 Q. Well, it's yes or no, isn't it?

12 MS. HERMIZ: Objection.

13 A. I don't -- I don't know that they're
14 inaccurate.

15 Q. That's not my question. My question
16 is, do you care if they're accurate or not?

17 MS. HERMIZ: Objection.

18 A. I don't have a response.

19 Q. How can that be, Doctor?

20 MS. HERMIZ: Counsel, at this point
21 I feel like you're harassing the witness here.
22 We've spent four hours on three exhibits that he
23 has told you that he has no personal knowledge
24 as to how they're made.

25 MR. CHEFFO: That's a different

1 question, though, counsel. I think we both know
2 that. But I understand your point.

3 MS. KEARSE: Why don't we take a
4 five-minute break.

5 MR. CHEFFO: That's fine.

6 MS. KEARSE: Do you want to take a
7 break?

8 MR. CHEFFO: Sure.

9 THE VIDEOGRAPHER: Off the record,
10 2:30.

11 (Recess had.)

12 THE VIDEOGRAPHER: Back on the
13 record, 2:50.

14 BY MR. CHEFFO:

15 Q. We're back on, Doctor.

16 With respect to the annual report,
17 are you aware of who ultimately reviews and
18 signs off on that report before it's issued?

19 A. I believe it's Dr. Kohler.

20 Q. Do you know if it's anybody above
21 her or in the county's office?

22 A. I'm not aware of anyone else in the
23 executive's department that might be reviewing
24 or signing off on the annual report. The report
25 is generated by whoever is designated to do the

1 office statistics, and it's reviewed by
2 Dr. Kohler.

3 Q. Has there ever been a time where you
4 were the designee for the office statistics?

5 A. Excuse me?

6 Q. Sorry. I probably mumbled that.
7 Has there ever been a time where you
8 were the designee for the office statistics?

9 A. No.

10 Q. And are you aware of any discussion
11 around any concerns about listing
12 methamphetamine in your statistics for your
13 department because of any perceptions about how
14 it may look to the outside world?

15 MS. HERMIZ: Objection. Form.

16 A. No.

17 Q. Nothing you've ever heard before?

18 A. No.

19 Q. And do you know who -- the person
20 who collected the statistics was for 2016?

21 A. I believe in 2016 Patrick Gillespie
22 was still with -- had not yet retired and was
23 still with the office and issued the 2016
24 statistical report.

25 Q. Now that we're almost in 2019, do

1 you know when 2017 and 2018 will be issued?

2 A. No.

3 Q. Do you know what the hold-up is?

4 MS. HERMIZ: Objection to form.

5 MS. KEARSE: I think 2017 --

6 MR. CHEFFO: Was it? I stand
7 corrected.

8 MS. KEARSE: That may be right.
9 2018 and --

10 Q. Well, if it has, then let me
11 withdraw it, because I was not aware of that,
12 and I don't want to ask you an unfair question.

13 Do you believe that opioid medicines
14 are beneficial for some people?

15 MS. HERMIZ: Objection to form.

16 A. Yes.

17 Q. Do you have a view as to who they
18 are appropriate for?

19 MS. HERMIZ: Objection to form.

20 A. Yes.

21 Q. Could you testify about that?

22 A. Opioid medications are useful for
23 pain management for individuals that are in --
24 undergoing surgical procedures and people --
25 individuals in their post-operative surgical

1 period. Opioid medications are useful for
2 people that are dealing with acute pain with
3 various disease processes. And opioid
4 medications are useful for people with, oh,
5 chronic pain due to various medical conditions.

6 Q. You mentioned earlier -- you
7 testified -- excuse me -- earlier about the
8 OARRS database. Do you remember that?

9 A. Yes.

10 Q. And correct me if I'm wrong, but I
11 think you said that your understanding was that
12 it was voluntary amongst doctors; is that right?

13 A. Yes.

14 Q. And that is your understanding?

15 A. Yes.

16 Q. Is that something that you are
17 certain of or you believe to be true?

18 A. Well, I believe it to be true. I've
19 never heard otherwise, that it's anything other
20 than voluntary.

21 Q. You're not aware of any rules or
22 regulations that make it mandatory?

23 A. It's possible that various
24 institutions have their own internal rules and
25 regulations, but it's my understanding that it's

1 voluntary and, once again, I don't report to
2 the -- to OARRS because I'm not an
3 opioid-prescribing physician.

4 Q. Do you have a view one way or the
5 other as to whether it's the doctor's
6 responsibility to actually report when he or she
7 writes a prescription for an opioid, or do you
8 view OARRS as a tool for doctors to review so
9 that they can make a determination as to whether
10 a patient may be doctor shopping or may be
11 getting a prescription from some other source?

12 MS. HERMIZ: Objection to form.

13 Q. Do you understand my question,
14 Doctor?

15 A. That was awfully long.

16 Q. What do you think doctors -- what's
17 the interplay between a prescribing physician
18 and OARRS, in your understanding?

19 A. It's my understanding that the --
20 that OARRS allows physicians to communicate
21 amongst themselves and other prescribing
22 agencies to be aware of what active
23 prescriptions a patient might have and what
24 prescriptions a patient might have received in
25 the past.

1 Q. Do you understand OARRS to be a
2 system where doctors input information or where
3 the doctors review the system for information?

4 MS. HERMIZ: Objection to form.

5 A. Are you talking about clinical -- a
6 doctor that practices clinical medicine?

7 Q. Prescribing doctors.

8 A. It's my understanding that they can
9 do both.

10 Q. And do you understand who sets the
11 rules for whether participation with the OARRS
12 requirements are voluntary or not?

13 A. Who establishes the reporting rules
14 to OARRS?

15 Q. Right. The rules of the road.

16 A. You know, I'm not really sure if
17 it's a state level or federal level.

18 Q. Would you be an advocate for making
19 reporting mandatory to the extent that it wasn't
20 mandatory?

21 MS. HERMIZ: Objection to form.

22 A. I haven't really considered that
23 question.

24 Q. I ask because I think earlier you
25 told us that one of the limitations you have is

1 that it's voluntary and you saw that as a
2 potential limitation, or at least that was my
3 takeaway from your testimony. Was that a fair
4 takeaway?

5 A. It's fair. If it's not --
6 physicians that do not report routinely to OARRS
7 does make it more of a limited tool; however, I
8 can't say -- I can't testify that it's my
9 opinion all physicians must or should be
10 reporting to OARRS because I'm -- really haven't
11 been involved in the clinical side of it, where
12 physicians have decided it's beneficial not to
13 report to OARRS, so I just don't know enough
14 about the issues surrounding that aspect of
15 OARRS.

16 Q. Have you -- either in preparation
17 for this deposition or, frankly, in the last ten
18 years, have you looked at any labeling for any
19 opioid medicines?

20 MS. HERMIZ: Objection to form.

21 A. You mean the prescription, the box
22 packet that comes with the prescriptions?

23 Q. I'm talking about things that would
24 be in a PDR, you know, a package insert.

25 A. Yeah, I've reviewed package inserts.

1 Q. What's the occasion -- strike that.
2 For opioids you've done that?

3 A. For a broad variety of drugs,
4 including opioids.

5 Q. Why do you do that?

6 A. To -- there are instances where it's
7 necessary to review what is reported,
8 indications and what might be not listed as an
9 indication for prescribing, what might be listed
10 as a complication, or what might be absent as a
11 listed complication of any given medication.

12 Q. Do you have a view as to whether any
13 of the Defendants in this case engaged in any
14 wrongful conduct?

15 MS. HERMIZ: Objection to form.

16 A. I don't have an opinion right now
17 that -- or currently that any of the Defendants
18 have performed wrongful conduct.

19 MR. CHEFFO: If you could mark this,
20 please.

21 - - - - -

22 (Thereupon, Deposition Exhibit 5,
23 E-Mail from Lisa Kohler to George
24 Sterbenz and Todd Barr, dated
25 September 12, 2017, Beginning Bates

1 Number SUMMIT_000117014, was marked
2 for purposes of identification.)

3 - - - - -

4 Q. This is a short one, Doctor. Let me
5 give you a minute to take a look at it. Tell me
6 when you've had a chance to read it.

7 A. Yes.

8 Q. Do you recall this e-mail?

9 A. Yes.

10 Q. Could you explain both the context
11 in which it was sent and perhaps help us
12 understand what it means?

13 A. Okay.

14 So the e-mail says, "Hypoxic
15 ischemic encephalopathy due to unexpected
16 cardiac arrest, status post-resuscitation, due
17 to probable fentanyl analog overdose." The
18 following line is -- it's being abbreviated ACC.
19 That's box 33F on the death certificate, how
20 injury occurred, and stating "unconfirmed
21 illicit drug overdose."

22 Dr. Kohler says here, "I think the
23 wording -- that wording, similar to this work
24 on -- will work on many of our probable
25 overdoses that die in the hospital for whom we

1 cannot confirm the presence of illicit fentanyl
2 drugs." This specific setting -- so what this
3 is is a -- is a wording for a cause of death,
4 and it's -- on the death certificate there is
5 part 1 cause of death and part 2 cause of death,
6 and this would be the format for wording in part
7 1 cause of death. So line one would be the
8 immediate mechanism of death and, in this case,
9 hypoxic ischemic encephalopathy, which can be
10 abbreviated HIE. And then there will be lines
11 that say "due to" and "due to" and "due to."
12 And in this instance this person had hypoxic
13 ischemic encephalopathy due to having a cardiac
14 arrest and then being resuscitated. Since
15 they -- since their heart stopped for a period
16 of time, their brain didn't get enough blood,
17 therefore, didn't get enough oxygen, even after
18 their heart was restarted, and so they had
19 irreversible anoxic brain injury or hypoxic
20 ischemic encephalopathy.

21 And there was indication, based upon
22 investigative information, that this person had
23 an illicit drug overdose or illicit drug
24 toxicity that turned into a drug overdose that
25 was some type of fentanyl analog.

1 And then the conundrum in many of
2 these instances is, is it better to leave these
3 deaths unclassified or is it to -- better to
4 give them a classification, recognizing that the
5 degree of certainty might not be 99 percent
6 certainty, for example, but is more likely -- is
7 a more likely than not degree of certainty.

8 Q. To a reasonable degree of medical
9 certainty?

10 A. Reasonable degree of medical
11 certainty is not a set percentage. At the bare
12 minimum, it needs to be more likely than not,
13 which is 51 percent certain. And it's desirable
14 to be -- have a higher degree of certainty,
15 obviously, than the bare minimum degree of
16 certainty, and so one can choose, when the
17 certainty is lower, such as just 51 percent or
18 50 something percent, to say, well, maybe it's
19 better to classify as undetermined, with some
20 kind of comment that there's a suspicion for
21 illicit drug overdose; or one can look at the
22 strength of the investigation and say, even
23 though it's not possible to confirm the presence
24 of fentanyl analogs, because in individuals that
25 die in the hospitals, one cannot do a drug

1 screen on these individuals from specimens
2 obtained on them at the time of their death in
3 most instances because they've had a delayed
4 death and their blood -- or specimens that one
5 would obtain at the time of their death, hours
6 or days following the actual overdose period,
7 are not representative of what their overdose
8 would have been or what their toxicology would
9 have been in their specimens at the time of
10 their acute drug overdose. So one can't go back
11 in time and grab that specimen, particularly if
12 the hospitals haven't retained admission
13 specimens.

14 And that's what happened in this
15 situation. There was not -- if I remember
16 correctly, there was not an admission specimen
17 available. The individual survived too long of
18 a period of time to be able to do a post-mortem
19 drug screen at that point, and there was
20 investigative evidence to indicate that there
21 was a probable fentanyl analog overdose
22 toxicity.

23 Q. Let me just ask you a few questions.
24 Thank you for that.

25 So this is not written for one

1 specific case, right? This is a -- kind of a
2 going-forward policy, right? It says, "I think
3 the wording similar to this will work on
4 many" -- not this one -- "many of our probable
5 ODs that die in the hospital for whom we cannot
6 confirm the presence of illicit drugs." Right?

7 A. So this was a specific case, and
8 this was a specific -- this was a specific death
9 on a specific decedent. I don't recall their
10 name, but this was a specific death on a
11 specific decedent. This is an individual who
12 lingered in the hospital for a period of time,
13 which I don't recall if -- I think it was a
14 period of days, and it was such a long period of
15 time that, unfortunately, the hospital didn't
16 retain any admission specimens -- either there
17 wasn't admission, they didn't retain admission
18 specimens or, if they had it, they were not of a
19 sufficient quality to be able to screen. It was
20 that type of situation. But there was strong
21 investigative evidence to indicate that this
22 person was actively abusing illicit drugs and,
23 in this instance, there was investigative
24 evidence to indicate that they were using some
25 type of fentanyl analog.

1 Q. Now --

2 A. So Dr. Kohler is saying that this is
3 not the way we should certify all deaths.
4 Dr. Kohler is saying, well, this is a way of --
5 so this is a cause of death, on a case that was
6 mine, for a specific case that I was -- that I
7 had conferred with Dr. Kohler to get her opinion
8 as to if this was a reasonable certification for
9 that specific individual. And Dr. Kohler, I
10 believe, was, if I remember correctly, sharing
11 this certification for this specific individual
12 with Dr. Barr, who had similar cases of
13 individuals suffering delayed deaths following
14 probable drug toxicities.

15 Q. So let me ask you this, Doctor. We
16 spent a fair amount of time on Exhibit 2, and
17 then 3 for a little bit, where I thought, in
18 order to have a cause of death, you told me a
19 number of times, it was a reasonable degree of
20 medical certainty.

21 A. That's correct.

22 Q. But is it your testimony that in
23 this case it's not a reasonable degree of
24 medical certainty; it's a, what lawyers might
25 say, a preponderance, it's a 51 percent

1 standard?

2 MS. HERMIZ: Objection to form.

3 A. A reasonable degree of medical
4 certainty in some instances needs to be no
5 greater than 51 percent certainty.

6 Q. So that's your standard, reasonable
7 degree is 51 percent?

8 A. No. As I stated earlier, reasonable
9 degree of medical certainty, the term
10 "reasonable degree of medical certainty" is
11 stated quite frequently, but the -- how it's
12 quantitated is not -- or -- there is no legal
13 specificity for what that means in terms of
14 degree of certainty. And one person might look
15 at the evidence and say, well, I'm 90 percent
16 certain and another might say, well, I'm only 75
17 percent certain.

18 Q. For you, Doctor, what would it --
19 for you to make a determination of reasonable
20 degree of medical certainty, when you put your
21 name and signature on it, what is your
22 percentage or how do you quantify it?

23 MS. HERMIZ: Objection to form.

24 A. The degree of what I would estimate,
25 my degree of certainty mentally, as in terms of

1 percentage, depends upon the specific case. So
2 in this instance, for this specific individual,
3 after considering the evidence that was
4 available, I felt that this fulfilled the
5 requirement for reasonable degree of -- of
6 certainty, and, particularly, recognizing that
7 this is not a -- a certification near absolute
8 certainty, which absolute certainty is never
9 required; and by stating in the cause of death
10 statement that this is a probable fentanyl
11 analog overdose, it's -- it's representing that
12 this is a case where the degree of certainty is
13 sufficient for certification, but it recognizes
14 that the -- that the level of certainty is not
15 as high as in other cases, for example, other
16 cases where the fentanyl analog can be confirmed
17 with a biological specimen.

18 Q. So is reasonable degree of medical
19 certainty a sliding scale?

20 A. Reasonable degree of medical
21 certainty is not a fixed scale. Reasonable
22 degree of medical certainty is -- is on a
23 case-by-case basis.

24 Q. And even within the individual
25 doctor, it could change?

1 A. Yes.

2 For example, for homicide -- for an
3 instance where I'm certifying a death as a
4 homicide, I am going to always require of my
5 certification to be -- have a very, very high
6 level of certainty.

7 For instances of individuals dying
8 of apparent natural disease, where there's no --
9 absolutely no concern for unnatural death, the
10 degree of certainty then can be lower, and that,
11 more likely than not, on a case-by-case basis --
12 in this instance, for example -- well, for drug
13 overdose deaths, where we can confirm the --
14 toxicologically the -- an illicit drug within a
15 biological specimen, the degree of certainty can
16 be very, very high. In this instance, where
17 it's not -- there's no specimens available to
18 test anymore, one has to decide what their
19 degree of certainty is based upon the
20 investigation alone.

21 Q. So the degree of certainty here is
22 kind of a 51 percent in this specific case and
23 it's an overdose case?

24 A. No. That's not -- I would not say
25 that the degree of certainty was 51 percent.

1 Q. More likely than not?

2 A. I don't recall enough of this, with
3 regard to this specific case investigatively, to
4 estimate the degree of certainty, if the degree
5 of certainty was only 51 percent. If I felt at
6 the time of certification that the -- the
7 certainty was only 51 percent, for example, I
8 probably would have just opted to give a
9 qualified undetermined cause of death.

10 Q. So it's more than 51 percent but
11 something less than a homicide standard?

12 A. I would say it's -- I would have to
13 review the specific case, which I don't recall
14 what the specific case was, because there's more
15 than one -- there were a number of individuals
16 that died under these type of circumstances with
17 unconfirmed fentanyl analog toxicity.

18 Q. By your own terms, Doctor, it says,
19 "probable fentanyl overdose, unconfirmed."
20 That's not a high level of specificity like we
21 saw in some of the others, where there's
22 toxicological data you had in some of your other
23 cases?

24 A. That's exactly what the
25 certification statement is recognizing, that

1 the -- there is enough certainty to classify
2 this individual's death as a drug overdose,
3 recognizing that the certainty is lower than in
4 instances where quality biological specimens are
5 available.

6 Q. And for statistical purposes, that
7 case would be classified as an overdose death,
8 right?

9 A. Yes.

10 Q. Is there any, that you can think of,
11 any economic benefit to the department, the
12 medical examiner's department, to have cases
13 classified as overdose deaths?

14 MS. HERMIZ: Objection to form.

15 A. Not that I'm aware of.

16 Q. I mean, in terms of trying to get
17 more funding, is -- you know, to the extent that
18 there's more data saying, oh, look at all these,
19 kind of, overdose deaths, we need more services,
20 is that used in a way that you've seen that
21 would impact, either negatively or positively,
22 budgetary issues?

23 MS. HERMIZ: Same objection.

24 A. Not specifically for drug overdose
25 deaths. Deaths that fall within our -- just

1 deaths in general, increased number of deaths in
2 general require more resources and more time on
3 the part of the medical examiner. The ultimate
4 mechanism of death isn't necessarily a budgetary
5 consideration beyond issues of what ancillary
6 tests the office might have to pay for. Perhaps
7 drug overdose deaths might require additional
8 toxicologic analysis that requires additional
9 spending.

10 Q. Are all potential overdose deaths
11 autopsied?

12 A. In general, all suspected drug
13 overdose deaths will be autopsied.

14 Q. And that's not true for all deaths
15 generally, right?

16 MS. HERMIZ: Objection to form.

17 A. Well, for individuals that suffer
18 delayed deaths, where they've had -- like, in,
19 for example, an individual like this, who has
20 had a delayed death in the hospital, in many of
21 these instances they've had very extensive
22 ante-mortem clinical diagnostic testing.
23 They've had CTs and MRIs of their heads and
24 their brains. They've had CTs sometimes of
25 their chest and abdomen and so forth. They've

1 had all sorts of clinical testing and
2 physiological testing. In many of these
3 instances there's nothing -- there's no --
4 it's -- the necessity for doing an autopsy --
5 the period of time that necessitated doing the
6 autopsy has passed and they've had adequate
7 clinical documentation so that an autopsy is no
8 longer absolutely necessary; but this is not the
9 typical type of case that comes to the medical
10 examiner's office. In most instances the
11 individuals are dying at a scene, not in a
12 hospital. Or if they're dying in a hospital,
13 they're being pronounced -- they're already dead
14 and they're being brought to an emergency
15 department and pronounced dead. Those
16 individuals will have autopsies performed.

17 In terms of natural deaths, it
18 depends. On many -- we do many autopsies on
19 natural deaths, just not all natural deaths. It
20 depends if there's a compelling public need to
21 perform an autopsy examination, because the
22 medical examiner's office can perform an autopsy
23 without -- generally, without the consent of
24 next of kin. We don't ask next of kin if they
25 would like us to do an autopsy or they will

1 permit us to do an autopsy. We will tell the
2 next of kin that one is necessary due to a
3 compelling public need.

4 On some occasions there might be an
5 instance where, with a natural death, that a
6 family, next of kin, might be requesting the
7 medical examiner's office to do an autopsy, and
8 then we'll examine those instances to see if
9 there's sufficient forensic concern by the
10 medical examiner's office that it warrants the
11 medical examiner to perform an autopsy.

12 Q. Is the -- would you agree that the
13 data in the statistics from the medical
14 examiner's office can be used to impact public
15 policy both locally and statewide?

16 MS. HERMIZ: Objection to form.

17 A. Yes.

18 Q. And to that point, would you also
19 agree, so, for example, if you, and perhaps
20 police and other law enforcement were seeing,
21 you know, an uptick in violent crime, in
22 homicides, that may inform public policy about
23 how funds and resources should be spent in a
24 community, right? It could be at least one
25 factor that would be considered? Would you

1 agree with that?

2 A. Yes.

3 Q. And would you also agree that the
4 same would be true if there's an uptick in
5 carfentanil deaths in a particular year or
6 jurisdiction or time, that could inform public
7 policy because, at least the powers at be, the
8 government folks could make a determination
9 whether they needed to spend more time and
10 effort and resources on addressing that issue?

11 A. Yes.

12 Q. And that's why it's important for
13 the data and information to be as accurate
14 and -- as possible so that public policy
15 decisions and others can be made based on good
16 information?

17 MS. HERMIZ: Objection to form.

18 A. Yes.

19 Q. And the same would be true if
20 information from a local level, like the Summit
21 County Medical Examiner, was aggregated in terms
22 of regional, statewide, multi-state, federal;
23 it's important that all of those data points and
24 all that information is as accurate as possible
25 because, ultimately, if the information is not

1 accurate, the ultimate data that's aggregated is
2 going to be less useful?

3 MS. HERMIZ: Objection to form.

4 A. Could you repeat?

5 Q. Sure.

6 You've heard the term "garbage in,
7 garbage out," right?

8 A. Yes.

9 Q. What do you think that means?

10 A. Okay. Yes. It's important that the
11 statistics that are generated are accurate.

12 Q. Because they could have a cascading
13 effect; if local information is then aggregated
14 with other information and that information is
15 not accurate, the more inaccurate information
16 that gets aggregated, the less useful the
17 ultimate aggregation data is going to be, right?

18 MS. HERMIZ: Objection to form.

19 A. Yes.

20 MR. CHEFFO: Would you mark this,
21 please?

22 - - - - -

23 (Thereupon, Deposition Exhibit 6,
24 E-Mail String Beginning Bates Number
25 SUMMIT_000117010, was marked for

1 purposes of identification.)

2 - - - - -

3 Q. I'm going to give you a chance,
4 Doctor, to read this. I'm nearing the end of my
5 time, so I'm just going to ask you a few
6 targeted questions, if I could, but just let me
7 give you a chance to read this.

8 This is an e-mail -- are you done?

9 A. Pardon me?

10 Q. Are you done?

11 A. Yes.

12 Q. This is an e-mail from about a year
13 ago, October of 2017, from Dr. Kohler to you and
14 Todd Barr, correct?

15 A. That's correct.

16 Q. And she's forwarding on an e-mail
17 from an Angelina {sic} Genet or Genet
18 {phonetic}, who is a public health specialist
19 for the Summit County Public Health Department,
20 right?

21 A. Yes.

22 Q. And the sum and substance of this
23 e-mail is asking whether you or Dr. -- Todd Barr
24 was a doctor, right? He's a doctor, right?

25 A. He's a doctor.

1 Q. The sum and substance of this e-mail
2 is asking whether you or Dr. Barr would be
3 interested in serving on an overdose fatality
4 review board representing your office. Do you
5 see that?

6 A. Yes.

7 Q. Did you wind up serving on that
8 board?

9 A. No.

10 Q. Did Dr. Barr wind up serving on the
11 board?

12 A. I don't know if he did.

13 Q. Do you know if anybody did?

14 A. No, I don't know.

15 Q. Did you express an interest in
16 working on this?

17 A. No. I did not want to be on the
18 overdose fatality review board.

19 Q. Why?

20 A. I believe that I'm too familiar with
21 the, you know, specific individuals, and that --
22 that have died with drug overdoses, and I make
23 an effort to distance myself from individuals
24 that have specific connections to, you know,
25 family members and friends and so forth of

1 individuals that I've performed autopsies on.
2 And I try not to put myself in positions where I
3 might be pressured to discuss any type of active
4 investigations that I'm participating in. So
5 I -- I felt that there were probably other
6 people within our office that are more
7 appropriate to serve on the overdose fatality
8 review board than myself.

9 Q. And what -- I can't tell exactly,
10 but what is it that you understood, at least
11 from this e-mail, or maybe further discussions,
12 about what this role or this board would be
13 doing?

14 A. I didn't get further details. I was
15 under the impression it's some type of community
16 outreach board, because it does mention that
17 it's being established through the public health
18 department or through -- by a public health
19 specialist, Angela Genet.

20 Q. So is it fair to say that after this
21 e-mail and your consideration and determination
22 that it wasn't a project for you, that you had
23 nothing else to do with it?

24 A. That's correct.

25 Q. Have you received any more

1 information about this after this e-mail?

2 A. No.

3 Q. You couldn't talk about anything
4 that this organization did or didn't do?

5 A. No.

6 Q. Have you seen any data or statistics
7 regarding an increase in the last number of
8 years in deaths, overdose deaths, related to
9 prescription medicines?

10 MS. HERMIZ: Objection to form.

11 A. Statistics within Summit County?

12 Q. Yes.

13 A. I am aware that there is an increase
14 in overdose deaths, or there has been an
15 increase in overdose deaths during the period
16 that I had been with the office. I am not
17 specifically aware of an increase in overdose
18 deaths due to prescription medications.

19 Q. Would you also agree that the
20 increase in overdose deaths in the last two to
21 three years is driven by drugs and illicit
22 substances such as fentanyl, fentanyl analogs,
23 methamphetamine and cocaine --

24 MS. HERMIZ: Objection to form.

25 Q. -- and heroin?

1 A. I'm -- currently, and in the past
2 few years, it is my impression that the majority
3 of drug overdoses are due to street drugs, such
4 as what you've listed.

5 Q. Do you believe that that -- that
6 more can be done by government to address the
7 influx of those street drugs?

8 MS. HERMIZ: Objection to form.

9 A. I always think more could be done to
10 address the influx of street drugs, because the
11 influx of street drugs into the community
12 directly affects my workload, so I always
13 welcome more influx, but I -- of intervention
14 from other agencies, like law enforcement
15 agencies, but I believe our local law
16 enforcement agencies have been doing more, so to
17 speak, to address the influx of street drugs
18 into the community.

19 Q. And do you also believe that there
20 can be a crisis of illicit drugs completely
21 independent from any marketing or advertising of
22 corporations?

23 MS. HERMIZ: Objection to form.

24 Q. Should I be more specific?

25 A. Yes.

1 Q. So you would agree that there's a --
2 what's a word that we can agree on -- a crisis?
3 I know we don't -- you don't like the word
4 "epidemic," but there's a social problem with
5 respect to carfentanil; would you agree with
6 that?

7 MS. HERMIZ: Objection to form.

8 Q. There is a social problem with the
9 abuse of carfentanil in Summit County; would you
10 agree with that?

11 A. Yes.

12 Q. And you would also agree that
13 carfentanil is an illegal drug that has no human
14 benefit and is certainly not sold legally in
15 some other form for human use, right?

16 A. I am aware of no recognized clinical
17 application for carfentanil in humans. There
18 might be some -- some benefit to humans found
19 for carfentanil at some point in the future. It
20 is used as a veterinary agent, so I guess you
21 can argue that is a benefit to humans, but it
22 does not have a clinical application in humans
23 as far as I know.

24 Q. To your knowledge, it's become a
25 social problem or a social abuse crisis

1 independent of any advertising or promotion of
2 the product, right?

3 MS. HERMIZ: Objection to form.

4 A. It's -- it's an illicit drug. It's
5 not advertised. So there is no advertising for
6 carfentanil that I'm aware of.

7 Q. And yet it is a significant social
8 problem that's caused many of the deaths that
9 you see in your facility, right?

10 A. It has caused many deaths, yes.

11 Q. And the same would be true of
12 heroin, right, it's an illegal drug with no
13 advertising, yet it is subject to abuse and has
14 been responsible for many deaths in this
15 community?

16 A. Yes, it has.

17 Q. And the same would be true for
18 methamphetamine; it's an illegal drug that's
19 never been marketed or advertised or sold by any
20 company, yet it is a drug of significant abuse
21 and is a significant social problem in this
22 community; is that right?

23 MS. HERMIZ: Objection to form.

24 A. Methamphetamine is an illicit drug.
25 It's not marketed commercially, and it is a drug

1 that's abused within the community and it's a
2 problem.

3 Q. And the same would be true of
4 cocaine, right --

5 A. Yes.

6 Q. -- not marketed, a problem, and
7 became a drug of choice amongst many people,
8 even though it was not detailed or sold by any
9 pharmaceutical company, right?

10 A. That's correct.

11 Q. And the same would be true of PCP
12 and crack cocaine, right?

13 MS. HERMIZ: Objection to form.

14 A. PCP is not so much a problem here,
15 but cocaine, in any form, has been a problem
16 during the period of time that I've been
17 employed at the Summit County Medical Examiner's
18 Office.

19 Q. And marijuana is not legal in Ohio,
20 at least not yet, right, but I take it, it's not
21 a drug that's directly attributable to many of
22 the deaths that you see, but it is -- it is a
23 drug that's prone to abuse; is that fair?

24 MS. HERMIZ: Objection to form.

25 A. I have never certified a death of

1 marijuana overdose from cannabinoids derived
2 from a marijuana plant, only deaths of synthetic
3 cannabinoids.

4 MR. CHEFFO: We don't even need a
5 long break. Just like a two-minute. I think
6 I'm done. Just to give them a chance to orient
7 themselves.

8 THE VIDEOGRAPHER: Off the record,
9 3:37.

10 (Recess had.)

11 THE VIDEOGRAPHER: We are back on
12 the record, 3:53.

13 EXAMINATION OF GEORGE STERBENZ, M.D.

14 BY MR. EMCH:

15 Q. Dr. Sterbenz, you testified a lot
16 about two things, cause of death and manner of
17 death, right? And those are two things that you
18 indicated it is your job and the other forensic
19 pathologists in Summit County and other places
20 to certify; is that right?

21 A. Yes.

22 Q. And by that you mean that's a
23 certification of those two items, what was the
24 cause of death for this individual, what was the
25 manner of death for this individual, and that

1 goes on the death certificate?

2 A. Yes.

3 Q. And I want to make sure that I
4 understood your testimony earlier about the
5 cause of death correctly.

6 So is it correct that if the
7 forensic pathologist, you or one of your
8 colleagues in Summit County, determines, to a
9 reasonable degree of medical certainty, that a
10 particular type of drug or substance was a cause
11 of death, then you name that particular drug or
12 substance in the cause of death line?

13 A. Yes.

14 THE COURT REPORTER: I'm sorry.
15 Cause of death what?

16 MR. EMCH: Cause of death, and you
17 name the cause of death in that particular line.

18 A. You name the drug in the cause of
19 death.

20 Q. Yes. You name the particular drug
21 or substance in the cause of death line, right?

22 A. Yes.

23 There are some exceptions.
24 Sometimes an individual may have so many
25 different drugs that are present that are

1 generating a combined effect toxicity, that it
2 simply won't fit on the death certificate, and
3 in those instances, in a practical sense, the
4 only option is to list some kind of generic
5 term, like mixed drug toxicity, and then be
6 certain that all of the different drugs are
7 indeed listed accurately in the autopsy report.

8 Q. And, again, we saw many instances in
9 Exhibit 2 and Exhibit 3 where there were many,
10 many drugs listed in the toxicology report but
11 the cause of death would name only those that
12 you would determine to a reasonable degree of
13 medical certainty were a cause?

14 A. Yes.

15 And there are some forensic
16 pathologists who, when there's more than one
17 drug, tend to just say "mixed drug toxicity" on
18 the death certificate and then list the drugs
19 that they believe are part of the mechanism of
20 death in their autopsy reports.

21 Q. Okay. But again, we're still on the
22 same wavelength. If you make a determination to
23 a reasonable degree of medical certainty that a
24 particular type of drug or substance is a cause,
25 you cull that drug out and name it in the cause

1 of death?

2 A. Yes. So if the specific drug is
3 listed in the cause of death statement on the
4 death certificate, that specifically means that
5 that drug has reached reasonable degree of
6 certainty that it is part of the mechanism of
7 death, always recognizing that there's thousands
8 and thousands of drugs and that doesn't exclude
9 the possibility of other drugs that might be
10 present that were simply not detected with the
11 current capabilities of the methodologies.

12 For example, I think it was prior to
13 2016 the drug carfentanil was not on anyone's
14 radar and nobody was screening for it, and
15 should, for example, someone have had a heroin
16 and carfentanil toxicity in 2014, the
17 carfentanil would have been missed, the heroin
18 would have been picked up and only heroin would
19 have been included on the death certificate.
20 But that's just -- that's just the nature of the
21 beast. There's always a potential for other
22 intoxicating substances that might be present
23 that just are beyond the capabilities of the
24 current methodologies to -- for detection.

25 Q. But, of course, once you determined

1 and were able to detect carfentanil, if you
2 found it and determined to a reasonable degree
3 of medical certainty that it was a cause, then
4 it got listed in the cause of death?

5 A. Moving forward from that period of
6 time, yes.

7 MR. EMCH: Okay.

8 EXAMINATION OF GEORGE STERBENZ, M.D.

9 BY MS. RANJAN:

10 Q. Dr. Sterbenz, we met earlier. My
11 name is Brandy Ranjan. I'm an attorney with the
12 firm of Jones Day and I represent Walmart in
13 this lawsuit, and I'm going to ask you some
14 questions that, hopefully, won't take too much
15 more of your time because I'm sure you're ready
16 to wrap up. If at any time you need a break,
17 then just let me know.

18 Is that okay?

19 A. Yes.

20 Q. First, I'd like to cover if you ever
21 received -- did you ever receive a notification
22 to retain documents for this litigation?

23 A. Yes.

24 Q. When did you receive that?

25 A. I don't recall the exact dates, but

1 I've -- I've been -- received notifications at
2 least twice.

3 Q. When did you receive the first one
4 approximately? Has it been a year?

5 A. I don't -- I don't recall back a
6 full year with regard to the specific
7 litigation, but I know within the past few
8 months I've received two updated notifications.
9 We possibly might have gotten a notification
10 even farther back. I just don't recall at this
11 time.

12 Q. But ever since you received that
13 initial notification, you've been retaining your
14 documents related to this litigation?

15 A. Yes.

16 Q. And that includes both your
17 electronic documents, like e-mail?

18 A. Yes.

19 Q. And any electronic files that you
20 might have in, like, for instance, PDF or Word
21 form?

22 A. Yes.

23 Q. And it also relates to any paper
24 documents that you might have in your office?

25 A. Yes.

1 Q. And then at some point were you
2 asked to actually collect your documents and
3 give them to someone, maybe give them to your
4 attorneys, in connection with the lawsuit?

5 A. Yes. They had asked me to provide
6 any documents that I might have that are --
7 relate to the lawsuit.

8 Q. And did you comply with that
9 request?

10 A. I did.

11 Q. Did you go back and check your
12 e-mails to see if any of those pertained to this
13 lawsuit?

14 A. My e-mails?

15 Q. Yes.

16 A. No. I didn't -- I didn't go
17 screening my e-mails.

18 Q. Did any attorney ever collect your
19 e-mail file or any person ever collect your
20 e-mail file in connection with the lawsuit?

21 A. I was told it was, yeah.

22 Q. Okay. The reason why I'm asking is
23 because we saw surprisingly few e-mails from you
24 in the production in what your attorneys gave
25 us, and I was just curious if you have an

1 explanation for why that might be.

2 MS. HERMIZ: Objection to form.

3 A. Fewer e-mails than?

4 Q. Than most folks. Is it fair to say
5 that you receive a lot of e-mails every day?

6 A. I -- not particularly.

7 Q. On an average day, how much
8 communication by e-mail do you do?

9 A. I don't do communication by e-mail
10 daily.

11 Q. Okay. Do you receive e-mails daily
12 from other people?

13 A. The majority of the e-mail -- I do
14 receive e-mails daily.

15 Q. And you just don't respond to those?

16 MS. HERMIZ: Objection to form.

17 A. Well, a lot of the e-mail is junk
18 e-mail that's unrelated to work.

19 Q. Okay.

20 A. Some of the e-mails are county
21 notifications about outages of the wi-fi or
22 outages of the daily mail run, and, I mean --
23 you know, that type of e-mail. I receive
24 e-mails for notifications for exercise classes
25 and so forth with the county. But in terms of

1 work-related e-mails, I'll get the routine
2 administrative notifications from the -- the
3 office administrator, some updates from
4 Dr. Kohler. And some of the e-mails that
5 Dr. Kohler would get -- for example, I wouldn't
6 get administrative e-mails. And Dr. Kohler is
7 also active on the name listserv, which I'm not.

8 Q. Do you and Dr. Kohler correspond
9 about cases via e-mail?

10 A. Rarely.

11 Q. Okay. But to the extent that those
12 e-mails exist, do you typically delete them or
13 do you file them away somewhere?

14 MS. HERMIZ: Objection to form.

15 A. I've -- I can't remember the last
16 time that I've corresponded with Dr. Kohler
17 regarding any specific case through an e-mail.
18 We -- we have our offices virtually side by
19 side. I usually just talk to her directly.

20 Q. Do you and Dr. Kohler ever work
21 together on cases?

22 A. Do you mean like do we share --

23 Q. Do you collaborate?

24 A. -- death investigation
25 responsibilities?

1 Q. Yes. Do you collaborate on any
2 single case together?

3 A. Generally not. Generally, we have a
4 rotating on-call schedule. Those cases which I
5 assume during my on-call schedule are mine.
6 Those cases which she assumes during her on-call
7 schedules are hers.

8 We've gone through a period of time
9 now where, more often than not, we've been
10 short-staffed with forensic pathologists, and I
11 don't generally have the time to just
12 out-of-hand review her cases. On the other
13 hand, she, as the chief medical examiner, does
14 review my cases because she co-signs my cases,
15 whereas I do not co-sign her.

16 Q. Has she ever disagreed with you
17 about the cause or manner of death that you
18 determined in a case?

19 A. I don't ever recall her just
20 outright disagreeing with my -- with the cause
21 of death. If I am conferring with her regarding
22 a case, we can discuss, you know, the death
23 certification, we can discuss appropriateness
24 for manner of death classification, but in -- in
25 those instances, obviously my determination is

1 not -- you know, not solidified at that point,
2 so I'm specifically bringing cases to her to get
3 her perspective and her point of view, of
4 another forensic pathologist, in those cases.
5 The vast majority of cases that are mine, I
6 simply certify without telling her in advance
7 because there's just far too many cases that I
8 perform on -- every year to run every single
9 case past her, and she's far too busy to have me
10 run every single case past her; and of those
11 cases where they've already been certified,
12 gosh, I don't think she's ever said, this is
13 just absolutely wrong, it needs to be changed.

14 Q. How frequently do you do that type
15 of collaboration with her before you would
16 actually make the final determination on an
17 overdose case?

18 MS. HERMIZ: Objection to form.

19 A. A few times each year.

20 Q. What would be the circumstances that
21 might lead you to do that?

22 A. Well, for example, the individual
23 who I certified regarding Exhibit Number 5, I
24 felt that I had reasonable degree of medical
25 certainty to certify it with this type of

1 wording, but I -- I did present that case to
2 Dr. Kohler and we discussed it first.

3 Q. I want to talk to you about --
4 changing gears, I want to talk to you about your
5 involvement in professional associations. Are
6 you at all involved in -- and I assume, based on
7 your prior answer -- your prior testimony, that
8 your answer is probably no, but are you at all
9 involved in the ADM board?

10 A. No.

11 Q. Have you ever had any interaction
12 with the ADM board?

13 A. No.

14 Q. Are you involved in any other
15 governmental body in Summit County?

16 A. No.

17 Q. Are you involved in any professional
18 associations?

19 A. You mean like forensic pathologist
20 associations?

21 Q. Yes.

22 A. I keep an active membership with the
23 AAFS, the American Association of Forensic
24 Sciences.

25 Q. Anything else?

1 A. Yeah. I have on my CV listed the
2 National Association of Medical Examiners, but I
3 should qualify that I -- I haven't maintained,
4 in the past year or so, my -- my membership dues
5 with the National Association of Medical
6 Examiners, because I stopped going to their
7 meetings.

8 Q. And I'm sorry. What was the first
9 organization, the AAMF?

10 A. AAFS, American Academy of Forensic
11 Sciences.

12 Q. And how involved are you with them?
13 What is your involvement with them?

14 A. I'm not actively involved.

15 Q. Okay.

16 A. I don't have an active involvement
17 with the AAFS.

18 Q. Have you ever been asked to give any
19 presentations related to opioids?

20 A. Well, no, I don't -- I don't recall
21 giving any presentations, particularly since
22 I've been here in Ohio. I've -- I haven't done
23 presentations in the past few years.

24 Q. Prior to the past few years, do you
25 recall giving any presentations on the topic of

1 opioids?

2 A. No.

3 Q. Is it fair to say that you're not
4 familiar with the business practices of drug
5 distributors?

6 A. That's correct.

7 Q. You're not familiar with the laws
8 and regulations that govern drug distributors?

9 A. That's correct.

10 - - - - -

11 (Thereupon, Deposition Exhibit 7,
12 E-Mail from Lisa Kohler to Gary
13 Guenther, dated September 14, 2017,
14 with Attachment, Beginning Bates
15 Number SUMMIT_000201288, was marked
16 for purposes of identification.)

17 - - - - -

18 Q. Dr. Sterbenz, I've handed you a
19 document that was previously marked as Exhibit
20 7. It's an e-mail. It's from Dr. Kohler to
21 Gary Guenther, and the subject is "Opiates," and
22 the Bates number is SUMMIT_000201288. Attached
23 to the e-mail is a document labeled "Narrative
24 in Support of Opioid Crisis Costs, County of
25 Summit Medical Examiner."

1 Have you ever seen this document?

2 I'll give you a moment to review it.

3 A. No, I haven't seen this document
4 before.

5 Q. So I believe earlier you testified
6 that you don't have much visibility, if any,
7 into the budget of the office. Did I recall
8 your testimony correctly?

9 A. That's correct.

10 Q. So is it fair to say that you've not
11 been involved in preparing any type of damages
12 or cost analysis related to this lawsuit?

13 A. That's correct.

14 Q. In your typical job duties at the
15 Summit County Medical Examiner's Office, would
16 you ever be involved in something like that?

17 MS. HERMIZ: Objection to form.

18 Q. In the past -- let me ask it a
19 different way. In the past have you ever
20 prepared any type of analysis of the costs of
21 the office?

22 A. No.

23 Q. Or the expenditures of the office?

24 A. No. I have never done any type of
25 budgetary analysis for the office, for the

1 Summit County Medical Examiner.

2 Q. Okay. You can set that aside.

3 - - - - -

4 (Thereupon, Deposition Exhibit 8,

5 Copy of Ohio Revised Code Section

6 313.212, Notice of Death by

7 Overdose, was marked for purposes of

8 identification.)

9 - - - - -

10 Q. Dr. Sterbenz, you are aware that the

11 Summit County Medical Examiner's Office, its

12 duties are set forth in the Ohio Revised Code;

13 is that correct?

14 A. Yes.

15 Q. And specifically in Chapter 313?

16 A. Yes.

17 Q. I've handed you a portion of the

18 Ohio Revised Code. It's Section 313.212. I

19 believe you've had a moment to review it. Is

20 this something that you have ever seen before?

21 A. I've read through the 313's code, so

22 I must have reviewed it at some time in the

23 past, though I don't have the specific recall of

24 313.212 at this time.

25 Q. Okay. The section says, "If the

1 coroner determines that a drug overdose is the
2 cause of death of a person, the coroner may
3 provide a notice of the death to the State
4 Medical Board, Board of Nursing or State Dental
5 Board. The coroner may include in the notice
6 any information relating to the drug that
7 resulted in the overdose, including whether it
8 was obtained by prescription and, if so, the
9 name of the individual who prescribed it."

10 Did I read that properly?

11 A. Yes.

12 Q. Have you ever made a report as is
13 described in this section of the Ohio Revised
14 Code?

15 MS. HERMIZ: Objection to form.

16 A. I don't personally do reporting for
17 the office to other agencies. That would be
18 dealt with by other individuals within our
19 office.

20 Q. In the cases where you have been the
21 medical examiner assigned to the case, have you
22 ever thought, wow, you know, this particular
23 drug overdose, it's really something someone
24 should know about?

25 MS. HERMIZ: Objection to form.

1 A. Once again, I don't do direct
2 reporting for the Summit County Medical Examiner
3 to other agencies. The office, I know, does do
4 reporting to other agencies, and that's done by
5 other individuals within the office.

6 Q. But you have responsibility for the
7 cases where you're the medical examiner who is
8 assigned to that case, correct?

9 MS. HERMIZ: Objection to form.

10 Q. You're the person in the office
11 who's the most familiar with the cases where
12 you're the assigned medical examiner; is that
13 correct?

14 A. Yes. My responsibility is for
15 determining and certifying the death
16 certificate, cause and manner of death.

17 Q. And where there was a prescription
18 drug that was involved in that -- in an overdose
19 death, let's say, you're the person who would be
20 most familiar with the background of that case;
21 is that accurate?

22 MS. HERMIZ: Objection to form.

23 A. I would be familiar, yes.

24 Q. And so you would know if, you know,
25 that person, for instance, had a prescription

1 that -- well, let's just start there. You would
2 know, for instance, if that person had a
3 prescription drug that was involved in their
4 overdose?

5 A. Yes.

6 Q. And in the cases where you've been
7 the medical examiner, you've never made an
8 independent determination that, you know, this
9 particular prescription, it's just -- it's
10 something that I feel the need to report to the
11 state board?

12 MS. HERMIZ: Objection to form.

13 A. So the way this statute is written,
14 it's talking about "the coroner," and Summit
15 County is a medical examiner jurisdiction, there
16 is no coroner in Summit County, and it's written
17 as such, as "the coroner," because each county
18 has an elected coroner, except for Summit County
19 and Cuyahoga County. So the statutes that are
20 written for the coroner, therefore, then apply
21 to the medical examiner, and the medical
22 examiner, with a capital T, in Summit County is
23 Dr. Lisa Kohler, and I am a medical examiner, so
24 to speak, in Summit County. There certainly may
25 be autopsies which -- on individuals whom I

1 performed investigation -- or individuals whom I
2 performed autopsies on and death certifications
3 that have been reported to the state medical
4 board, but I am not the individual within our
5 office who would actually perform the -- the
6 reporting activity.

7 Q. So what you're saying is that it's
8 your belief that it would be Dr. Kohler's
9 responsibility to make the report that's
10 described in Ohio Revised Code Section 313.212?

11 MS. HERMIZ: Objection to form.

12 A. It's my understanding that
13 Dr. Kohler would be reviewing cases at the time
14 when she's co-signing cases and determining if
15 there is a need to refer specific cases to the
16 state medical board, because as the appointed
17 coroner -- I mean, as the appointed medical
18 examiner, the medical examiner for the state --
19 for Summit County, as the chief medical
20 examiner, she is the -- has the statutory
21 requirement to -- I mean, she's the individual
22 in our office to which this statutory
23 requirement is directly applying to, myself
24 indirectly, and I assist in that by performing
25 death investigations and then forwarding all of

1 my report information on to Dr. Kohler.

2 Q. Are you done with your answer?

3 A. Yes.

4 Q. Do you know if, in fact, Dr. Kohler
5 actually makes those reports?

6 MS. HERMIZ: Objection to form.

7 A. I don't know.

8 MS. RANJAN: I'm asking about his
9 knowledge. What's the basis for the objection?

10 MS. HERMIZ: The basis for the
11 objection, foundation. You're implying that
12 it's required to report, which, I mean, if you
13 want me to go on with my issues about this
14 question, I can go on, but I don't want to do a
15 speaking objection.

16 MS. RANJAN: No. It's fine. I'm
17 just asking about his knowledge.

18 MS. HERMIZ: Sure.

19 Q. Have you ever had a specific
20 conversation with Dr. Kohler about potentially
21 making such a report?

22 A. No.

23 Q. And you yourself have never reported
24 one of your cases to the authorities?

25 A. That's correct.

1 You mean to the state medical board?

2 Q. Correct.

3 A. Not --

4 Q. Is that how you understood my
5 question?

6 A. You said "the authorities."

7 Q. Yes.

8 You yourself have never made any
9 such report to the medical board?

10 A. To the state medical board, that's
11 correct.

12 Q. Right.

13 - - - - -

14 (Thereupon, Deposition Exhibit 9,
15 E-Mail String Beginning Bates Number
16 SUMMIT_000028995, was marked for
17 purposes of identification.)

18 - - - - -

19 Q. Dr. Sterbenz, I'm handing you
20 another e-mail. It is Bates labeled
21 SUMMIT_28995, and I realize that you are not
22 copied on this e-mail until the top, but I'm
23 going to cover some of the substance below that
24 you received.

25 So starting with the bottom of the

1 chain, the subject is "Discuss Tox Cases," and
2 it's an e-mail from Dr. Kohler to a Brian
3 LoPrinzi.

4 Do you know who Brian LoPrinzi is?

5 A. Brian LoPrinzi is with the Summit
6 County Prosecutor's Office.

7 Q. Okay. And Dr. Kohler discusses her
8 availability, and she says, "What days would you
9 be available to meet to discuss where we are
10 with tox issues and the court?"

11 And in the subsequent chain,
12 Mr. LoPrinzi responds, and gives her a date --
13 you'll see that -- and then eventually -- in the
14 next chain you're copied, and Dr. Kohler says,
15 again, to Brian LoPrinzi, copying you, "I'm
16 available on October 12th at 2 p.m. to discuss
17 the issues of toxicology in the courts for
18 overdose cases. Dr. Sterbenz is on call that
19 week and may be able to join us if his schedule
20 allows."

21 Did I read that correctly?

22 A. Yes.

23 Q. Do you recall receiving this e-mail,
24 first of all?

25 A. I don't specifically recall

1 receiving it.

2 Q. Do you recall if indeed any kind
3 of -- strike that.

4 Do you recall ever participating in
5 such a meeting with Mr. LoPrinzi?

6 A. I vaguely remember. It's two years
7 ago. I vaguely remember discussing issues with
8 the prosecutor's office and -- or expediting our
9 certifications for drug-related deaths.

10 Q. So Mr. LoPrinzi specifically wanted
11 to meet with you and Dr. Kohler related to the
12 certification of drug-related deaths. Is that
13 what you're saying?

14 A. Expediting the certification of
15 drug-related deaths. In 2016 we were
16 short-staffed and there was a backlog for
17 signing out cases, for certifying cases, that
18 was becoming long, running into months, and
19 Mr. LoPrinzi was interested in having the
20 medical examiner's office expedite certification
21 of drug-related death, particularly on cases
22 that they were interested in -- in
23 investigating.

24 Q. And so Mr. LoPrinzi wanted to
25 discuss with you the reason why it was taking so

1 long for certain types of overdose deaths to be
2 certified?

3 A. I guess in part, and to see what
4 mechanism he could put in place to expedite
5 certifications of deaths which were of concern
6 to the prosecutor's office.

7 Q. Anything else that you discussed at
8 that meeting?

9 A. That's what that meeting was about.

10 Q. Okay. But you didn't discuss
11 anything else?

12 A. Not that I recall.

13 Q. And who else was present at the
14 meeting?

15 A. Dr. Kohler.

16 Q. Anyone else?

17 A. I think John Baumoel, who is cc'd on
18 this, might have been present.

19 Q. Who is he?

20 A. He's with the prosecutor's office.

21 Q. Okay.

22 A. I can't recall if we met in person
23 or if it was just by phone.

24 Q. You can put that aside.

25 - - - - -

1 (Thereupon, Deposition Exhibit 10,
2 E-Mail String Beginning Bates Number
3 SUMMIT_000092858, was marked for
4 purposes of identification.)

5 - - - - -

6 Q. Dr. Sterbenz, I'm showing you what's
7 been marked as Exhibit 10. This is an e-mail
8 chain from January of 2011, and you are copied
9 on the bottom e-mail. And in the e-mail
10 Dr. Kohler sent you an attachment, and then --
11 I'm sorry. This document is Bates labeled
12 SUMMIT_000092858 through 860.

13 Dr. Sterbenz, do you see that you
14 were copied on this e-mail?

15 A. Yes.

16 Q. And the subject is "Investigator
17 Report Information"?

18 A. Yes.

19 Q. And in it Dr. Kohler writes, "Here
20 is the document that I started for the
21 investigators. The goal is to put down the
22 types of information that we feel are important
23 to particular types of investigation and to
24 provide a brief explanation as to why it is
25 important. What I am sending is just a starting

1 point. Please add to and improve what is there,
2 and then we can distribute it to the
3 investigators. I believe that if they
4 understand the rationale behind why we are
5 asking for the information, they will more
6 quickly embrace the concept of including it."

7 Did I read that accurately?

8 A. Yes.

9 Q. Do you recall this document being
10 circulated?

11 A. This document was from the beginning
12 of 2011, and I don't have immediate recall of
13 it.

14 Q. The Summit County Medical Examiner's
15 Office has an investigator's manual; is that
16 right?

17 A. That's correct.

18 Q. Do you know why Dr. Kohler would
19 want to -- do you know why Dr. Kohler was
20 circulating this document -- strike that.

21 Do you recall if at any time there
22 was some type of an issue with compliance by the
23 investigators in relation to death
24 investigation?

25 A. Compliance, you mean the way they do

1 the investigation?

2 Q. Let me rephrase the question.

3 Was there a specific circumstance
4 that necessitated the circulation of this type
5 of information?

6 Dr. Kohler's cover e-mail speaks to
7 the investigators understanding the rationale
8 behind what's being asked of them.

9 A. Yes.

10 Q. Do you know why that would have been
11 a concern to her, based on your experience at
12 the office?

13 MS. HERMIZ: Objection to form.

14 A. I don't recall what was the specific
15 issue in 2011 that Dr. Kohler was -- decided to
16 generate or felt a need to generate this
17 correspondence.

18 Q. Let's take a look at the second page
19 of the document. There's a section labeled
20 "Overdose Deaths," and in it there's a section
21 on medication history. Do you see that?

22 A. Yes.

23 Q. And there are a number of items that
24 are listed there. Let's walk through them.

25 First, "what type of medications was

1 this person prescribed, by whom, and for what
2 ailment? Are the suspected OD drugs ones that
3 were prescribed for the victim or for family
4 members or friends? How did the decedent obtain
5 the medication? If the person is prescribed the
6 meds, how compliant have they been on this
7 regimen? Has the physician documented concerns
8 of abuse? How long have they been taking the
9 medication?"

10 Let's stop there for a moment. Do
11 you agree that those are all necessary data
12 points in a drug overdose investigation?

13 A. I mean, ideally it would be
14 phenomenal to have an unlimited amount of
15 information. All of this type of information in
16 reality -- in reality, the practical --
17 practicality sets in, and all of this -- this
18 type of information cannot be obtained for every
19 or even most decedents. So it would certainly
20 be nice to have all of this information; it's
21 certainly not absolutely necessary to have all
22 of this information to ultimately make a ruling
23 for cause and manner of death.

24 Q. Did you ever discuss these
25 requirements with the investigators?

1 MS. HERMIZ: Objection to form.

2 A. I'm sure I talked with the
3 investigators over and over again about what
4 type of information I would like them to obtain
5 and sent them back to go get additional
6 information to the point that they were annoyed
7 with me, and this whole memo might be about the
8 investigators annoyed with me for asking for
9 additional information over and over again.

10 Q. So the investigators get annoyed
11 with you because you feel that sometimes they
12 don't provide you adequate information?

13 MS. HERMIZ: Objection to form.

14 A. The investigators will provide me
15 information that they believe to be adequate or
16 they believe to be appropriate, but what they
17 believe to be adequate and appropriate is not
18 always what I believe to be complete, and I can
19 direct them to go and do additional
20 investigation, which I do do.

21 Q. And that additional investigation
22 would look for the things that are listed here?

23 A. It could include this type of
24 information, as Dr. Kohler has outlined for
25 them.

1 Q. And then under "Illicit Drug Use,"
2 she lists, "What type of drugs does this person
3 usually use and how do they administer it? Have
4 they had medical treatment related to drug use
5 or incarceration related to drug use? Are they
6 involved now or have they been involved in drug
7 rehab or with agencies such as community
8 services or methadone programs?"

9 Did I read that accurately?

10 A. Yes.

11 Q. And I assume that your answer would
12 be the same there, that this is probably
13 something that the investigators try to get but
14 don't always manage to meet your expectations?

15 A. If they don't obtain that
16 information initially and I feel it's important
17 or necessary to ask, I will direct them to go
18 back and obtain that information.

19 Q. So to the extent that any of the
20 items listed here in "Medication History" or
21 "Illicit Drug Use" are particularly pertinent to
22 a particular case, that would be found in the
23 case file?

24 MS. HERMIZ: Objection to form.

25 A. It could be found in the case file.

1 Q. It could be but it --

2 A. All of these questions can be asked
3 to next of kin, and they don't -- people
4 providing -- friends and family who might be
5 providing history might not tell us the full
6 truth, so these questions can be asked, but the
7 information -- they might just say they don't
8 know, they might give us an answer that's
9 incorrect. So this -- this is just standard
10 investigative -- or a standard investigative
11 approach for various types of deaths. It would
12 be expected that the investigators addressed
13 these, all or most of these types of issues,
14 during the course of their investigation, and
15 the lack of being able to -- being able to
16 obtain all of this information doesn't
17 necessarily negate the ability to have an
18 ultimate certification of cause and manner of
19 death.

20 Q. But you sometimes might have the
21 information and sometimes you might not?

22 A. Right, but an attempt should be
23 made.

24 THE VIDEOGRAPHER: Can I change the
25 video?

1 MS. RANJAN: Sure.

2 THE VIDEOGRAPHER: Go off the
3 record, 4:46.

4 (Short recess had.)

5 THE VIDEOGRAPHER: Back on the
6 record, 4:48.

7 - - - - -

8 (Thereupon, Deposition Exhibit 11,
9 E-Mail from George Sterbenz to Lisa
10 Kohler, dated February 5, 2015, with
11 Attachment, Beginning Bates Number
12 SUMMIT_000098977, was marked for
13 purposes of identification.)

14 - - - - -

15 Q. Dr. Sterbenz, picking up where we
16 left off, I've just handed you a document that's
17 been marked as Exhibit 11, and, for the record,
18 it's SUMMIT_000098977 through 981.

19 Do you recognize this document?

20 A. This was an e-mail from Dr. Kohler
21 from 2015.

22 Q. And I'll just say it appears to me
23 as if the e-mail was from you.

24 A. From me, 2015, yes.

25 Q. And it attaches a document, and your

1 subject line is "Investigatory Manual"?

2 A. Um-hum. Yes.

3 Q. And you said, "Here are my tweaks to
4 the" -- I think that's meant to read
5 investigation report section. Is that right?

6 A. That's correct.

7 Q. And there's a document that's
8 attached to the e-mail. Did you draft this
9 document?

10 A. Yeah. I believe this is mine.

11 Q. Why did you draft this document?

12 A. Because I have a strong opinion as
13 to the format that the investigator should use
14 for a logical investigation report, and this was
15 my attempt to get everyone on board with what I
16 wanted for an investigation report; but I'm not
17 the chief medical examiner, so I was presenting
18 it to Dr. Kohler to show her what I feel should
19 be the format for the investigation reports for
20 the investigators to follow.

21 Q. You were essentially pitching an
22 idea to your boss?

23 A. Yes.

24 Q. And how was that idea received?

25 A. We've moved more into this

1 direction.

2 Q. That's one answer, but it wasn't
3 really an answer to my question. I'm curious
4 about how Dr. Kohler received your suggestions.

5 A. I think she received it positively,
6 and I think the investigators have moved more
7 into this direction.

8 Q. And is that a result of your efforts
9 to bring them along on board with your
10 suggestions?

11 A. Yes.

12 Q. Are you involved in any other way
13 with training the investigators?

14 A. Well, the investigators have a
15 specific -- okay. When the investigators join
16 the office, they have a specific training
17 period, and I am not directly included as one of
18 their trainers. They are trained by the other
19 senior investigators. So I don't know if I
20 would call this exhibit, this e-mail, which is
21 Exhibit Number 11, part of their training, but
22 in a sense, I guess, if I'm a big enough nag, it
23 becomes training.

24 Q. Yeah. I noticed you chuckling about
25 the document. I think if one of your -- if one

1 of the investigators in the office described you
2 as a stickler for this, would that surprise you?

3 A. Yeah. No, I would not be surprised.

4 Q. So this document includes some
5 things that you believe are important for the
6 investigators to include in their reports; is
7 that right?

8 A. Yes.

9 Q. So looking at Section B, it reads,
10 "The second paragraph should provide the
11 pertinent past medical history of the decedent."
12 And it says, "Include the source of your
13 information. Although a documented primary
14 source of medical history, such as a medical
15 record is most favorable, sometimes the only
16 source of information may be a family member or
17 friend."

18 Did I read that accurately?

19 A. Yes.

20 Q. I think that's consistent with your
21 prior testimony that, you know, sometimes you
22 want the medical records, but they're not always
23 available to review?

24 A. The medical examiner's investigation
25 should include medical history, past medical

1 history, or even current medical history that's
2 pertinent to the medical examiner. It's not
3 meant to be a comprehensive history of the
4 decedent's entire past medical existence.
5 That's generally not possible, nor necessary,
6 and impractical given the number of cases that
7 we need to manage during the course of the year.
8 But it should include information that's
9 pertinent to the medical examiner. That's why,
10 under number 2, I indicated that minor or
11 irrelevant diagnoses, such as seasonal
12 allergies, generally need not be listed. I can
13 be told about their hay fever, but that's not
14 really going to help me generate an opinion for
15 cause and manner of death.

16 Q. But to the extent that it is
17 relevant to the investigation, you would prefer
18 to have the medical records as opposed to just a
19 statement from a family member, for instance?

20 A. It's most desirable to obtain
21 information from a primary source, and in most
22 instances that primary source indeed will be a
23 medical record. In the absence of the medical
24 record or if there's an inability to obtain a
25 medical record, well, family and the next of kin

1 and friends are also a -- can be a source of
2 information, or both can be used.

3 Q. And then item 4 says, "Do list
4 pertinent prescription medications, such as
5 narcotic drugs." Did I read that accurately?

6 A. Item 4, yes.

7 Q. Did you have issues with the
8 investigators failing to list pertinent
9 medications in the past?

10 A. There were instances where some
11 investigators were not as fastidious about
12 obtaining prescription history and so might not
13 initially obtain that history until directed to
14 do so. On the other hand, there are
15 investigators that, in a shotgun fashion, list
16 every single medication. That's just
17 distracting and unnecessary and irrelevant. So
18 that's why I felt a need to indicate to list
19 pertinent medications to the investigation.

20 Q. And it's fair to say that you would
21 always want them to list pertinent
22 non-prescription medications as well; is that
23 right?

24 MS. HERMIZ: Objection to form.

25 A. Are you referring to

1 over-the-counter medications?

2 Q. No. I'm referring to illicit drugs.

3 A. So illicit drugs are not
4 medications. I mean, those are -- I mean,
5 they're not --

6 Q. Sure. That's fair.

7 A. -- medicines or medications.

8 Q. That's fair. Let me ask the
9 question in a different way.

10 It's fair to say that you would also
11 want them to list any illegal drugs in the
12 investigation report as well, correct?

13 A. Yes. That's obviously part of the
14 pertinent medical history. See, that might be
15 medical history that might not be obtainable
16 through clinical documentation. It might be
17 better obtained through friends and next of kin.

18 Q. And that's why in your next example
19 you specifically list whether the decedent had a
20 history of drug abuse as an example?

21 A. As an example, yes.

22 Q. That's something that you would want
23 the investigator to look for?

24 A. Exactly.

25 Q. And so you were providing the

1 investigators additional guidance to look for
2 those things?

3 A. Exactly.

4 Q. Because you felt that it hadn't
5 always been consistently done that way in the
6 past?

7 MS. HERMIZ: Objection to form.

8 A. Because it hadn't been reliably done
9 in the past. I can say certainly with deaths
10 that I was participating in the investigation
11 of, it eventually got done.

12 Q. Okay. Changing gears for a moment,
13 based on your prior training as a medical
14 doctor, you had some -- at least some education
15 in addiction; is that correct?

16 A. Yes.

17 Q. And as a part of that training and
18 based on that training, would you agree with me
19 that all addictions can be overcome?

20 MS. HERMIZ: Objection to form.

21 A. What do you mean by "overcome"?

22 Q. I mean someone who you would
23 characterize as addicted could come to a place
24 where they are no longer addicted.

25 MS. HERMIZ: Same objection.

1 A. The way you phrased the question, I
2 think, is a concept that is held to be
3 potentially -- something that could be
4 potentially true by the general public. I think
5 most individuals in the medical community view
6 addiction to any substance, including legal
7 substances, like tobacco and alcohol, a
8 life-long process that's managed rather than
9 cured necessarily, more like having cancer,
10 where -- where -- a more advanced stage of
11 cancer where it's not possible to cure it per se
12 but it can be managed over a period of time.

13 Q. So someone who is addicted to a
14 substance can make changes that will lead to
15 their ability to manage that addiction?

16 MS. HERMIZ: Objection to form.

17 A. Can you repeat that?

18 MS. RANJAN: Can you read the
19 question back to him?

20 (Record read.)

21 A. I think the answer is yes. When you
22 say "make changes," you're -- I think you're
23 implying make behavioral changes --

24 Q. Sure.

25 A. -- life behavioral changes that will

1 help them, in a behavioral sense, avoid their
2 addiction cycle of -- or their cycle of using --
3 using substances abusively. I think that's a
4 fair statement for management of individuals
5 clinically with drug -- with substance abuses.
6 The goal is to manage their addiction cycle --
7 sometimes that's a terminology that's used -- to
8 help them stay clean, stay off of drugs, rather
9 than relapse and go back to using, whether it's
10 alcohol or street drugs or improperly used
11 prescription drugs.

12 Q. In other words, it requires a
13 decision on the part of the person who is
14 addicted?

15 MS. HERMIZ: Objection to form.

16 A. Well, we're getting farther afield
17 from my area of expertise, so I don't know
18 enough about the clinical and -- the
19 psychological clinical approach to addiction
20 management to talk in terms of patient
21 management in that level of detail.

22 Q. So we would need to ask someone who
23 has the proper clinical training those types of
24 questions?

25 A. Yes.

1 Q. And I believe you testified earlier
2 that you don't do clinical work?

3 A. That's correct.

4 Q. Because your patients are deceased?

5 A. Right. I don't practice clinical
6 medicine. I mean, technically I could. I hold
7 a medical license in the State of Ohio that
8 allows me to practice medicine and surgery. If
9 I wanted -- I mean, it would be advisable, I
10 think, if I wanted to go back and practice
11 internal medicine or surgery, that I go back and
12 do a residency in internal medicine and surgery,
13 but for my career I've practiced pathology and
14 indeed forensic pathology.

15 Q. And if you wanted to start
16 diagnosing someone in a clinical setting as
17 addicted to substances, for instance, you would
18 also need additional training?

19 A. I'm not -- I don't think -- I
20 actually don't think I'm required to get
21 additional training according to my -- my
22 medical license, but I think that would be
23 desirable and it's not something that I'm going
24 to do.

25 Q. If we wanted to make a determination

1 about whether any particular individual who came
2 through your office as a deceased individual and
3 had an autopsy and an investigation -- if we
4 wanted to make a determination about whether
5 that individual decedent was, during their
6 lifetime, addicted to a particular substance, we
7 would need to review that particular case file
8 in order to do that, correct?

9 MS. HERMIZ: Objection to form.

10 A. You would have to do an
11 investigation into -- on that particular
12 individual. The case file itself or the medical
13 examiner investigation may or may not include
14 that information depending upon the extent of
15 the medical examiner's investigation. I can't
16 guarantee that if you go back to a medical -- to
17 the case file, that there will be the specific
18 information that you're looking for --

19 Q. Um-hum.

20 A. -- because it's the purpose of the
21 medical examiner investigation to facilitate
22 cause and manner of death investigation.

23 For example, for homicide deaths,
24 for individuals that are gunshot wound
25 fatalities, there are issues that are important

1 to the medical examiner that are not necessarily
2 important to the police department, and there
3 are issues that are important to the police
4 department that aren't important to the medical
5 examiner.

6 So the information -- all the
7 information regarding a case might not be
8 included in the medical examiner's case file.
9 It's going to deal with information that's
10 important to the medical examiner.

11 Q. And the information that would
12 determine whether or not a person was
13 specifically addicted to a substance may not be
14 in that file?

15 A. It could be, but it might not be. I
16 don't know. We'd have to look at individual
17 cases.

18 Q. But if someone with the particular
19 clinical training wanted to set out about that
20 inquiry, they would need to look at, like you
21 said, each case individually?

22 MS. HERMIZ: Objection to form.

23 A. Yes. I believe you would look at
24 the individual cases that you had questions
25 regarding.

1 Q. For instance, they would need to
2 know things like how frequently the person used
3 the substance?

4 A. For -- for just -- what are we
5 talking about, their level of addiction?

6 Q. We're talking about determining
7 whether the person, during his or her lifetime,
8 was addicted to a substance, and if someone with
9 the proper clinical training wanted to make that
10 determination, they would need to, for example,
11 look at things like how long the person abused
12 the substance?

13 MS. HERMIZ: Objection to form.

14 A. Just one substance?

15 Q. Just -- yeah, hypothetically. Let's
16 say, you know, someone with the proper clinical
17 training wanted to determine whether a
18 particular person, during their lifetime, was
19 addicted to -- choose your drug -- heroin; they
20 would need to make an individual determination
21 about that person, right?

22 For instance, they couldn't look at
23 a report like Exhibit 2, that's in front of you,
24 and tell, based on these statistics, how many of
25 these individuals were addicted?

1 A. Oh. So you're asking about
2 chronicity of their use?

3 Q. You'll have to explain that term to
4 me. I'm not familiar with it.

5 A. So -- so a document like Exhibit 2,
6 which lists cause and manner of death and a
7 portion of the drug screen does not necessarily
8 let us know what the chronicity of the
9 decedent's drug use was, if this is a one-time
10 use of drug or if they had been using for a year
11 or two years or 20 years, if that's what you're
12 asking.

13 Q. That's not exactly what I'm asking.
14 I am asking about the factors that a clinical
15 practitioner would need to look for in order to
16 determine whether an individual is addicted to a
17 substance.

18 A. In a living person?

19 Q. Yes, in a living person.

20 MS. HERMIZ: Objection to form.

21 Q. If you know. If you don't know,
22 that's okay. You can just say so.

23 A. So you're deviating from death
24 investigation into clinical medical practice?

25 Q. Correct.

1 A. And I think you're now exceeding the
2 scope of my -- of my expertise.

3 Q. Okay. That's fair.

4 MS. RANJAN: Let's go off the
5 record.

6 THE VIDEOGRAPHER: Off the record at
7 5:09.

8 (Recess had.)

9 THE VIDEOGRAPHER: We're back on the
10 record.

11 BY MS. RANJAN:

12 Q. Dr. Sterbenz, I want to go back to
13 Exhibit 2 for a moment. Are you looking at the
14 correct exhibit? Yes. Okay. So I just have a
15 couple of follow-up questions along the same
16 lines as where we previously left off and then I
17 think we will wrap up.

18 So I wanted to ask you if a
19 doctor -- if a clinical doctor with the
20 appropriate training wanted to make a
21 determination about how many of the individual
22 decedents listed in Exhibit 2 were addicted
23 during their lifetimes, the information that
24 that clinical doctor would need is not available
25 in Exhibit 2; is that an accurate statement?

1 A. No.

2 Q. It's not an accurate statement?

3 A. I mean, the information -- when you
4 say they're addicted, you're -- you're asking,
5 can one state that the -- the various decedents
6 had chronic drug abuse as well as acute?

7 Q. Correct. Is that something that we
8 can determine based solely on Exhibit 2?

9 A. No.

10 Q. And do you have Exhibit 4 there in
11 front of you? If you could grab it, please.
12 It's the annual report, the 2016 annual report.

13 A. Yes.

14 Q. You looked at some toxicology
15 figures that were in this 2016 annual report.
16 Do you recall that?

17 A. Yes.

18 Q. And I assume that your answer would
19 be the same, that a clinical doctor with
20 appropriate training would not be able to make a
21 determination about whether any particular
22 individuals were addicted to a substance during
23 their lifetimes based solely on these toxicology
24 stats?

25 A. That's correct.

1 Q. And in order to make that
2 determination, we would need some additional
3 information, right?

4 A. You could look at the death
5 certificates for box 33F.

6 Q. So it's your testimony that the
7 death certificates --

8 A. Could be helpful.

9 Q. -- would tell us whether any
10 particular individual was addicted during his or
11 her lifetime?

12 MS. HERMIZ: Objection to form.

13 A. It could. It could be helpful for
14 an indication of chronicity of the drug abuse,
15 but the box 33F could state, for example, acute
16 and chronic or chronic active drug abuse.

17 Q. And in your mind, that's the same as
18 the person being addicted during his or her
19 lifetime?

20 MS. HERMIZ: Objection to form.

21 A. Well, the classification of chronic
22 abuse is as close as you're going to get to the
23 clinical classification of addiction, I
24 believe --

25 Q. So you made --

1 A. -- for a decedent.

2 Q. I'm sorry. I didn't mean to cut you
3 off.

4 So you make clinical determinations
5 about addiction on your death certificates;
6 that's your testimony?

7 MS. HERMIZ: Objection to form.

8 A. No, but the death certificate can --
9 it could possibly reflect a finding of
10 chronicity of drug abuse, and it might be also
11 reflected in the autopsy report --

12 Q. Um-hum.

13 A. -- and the investigation report, a
14 chronicity of drug use, abuse.

15 Q. So the information may be there, but
16 it may not be, right?

17 A. That's correct.

18 Q. There may be other information that
19 you need to look for; for instance, reviewing
20 the case file for that particular decedent might
21 be useful?

22 A. Well, if there was documentation of
23 chronic drug use in records obtained by the
24 medical examiner's office, I assume it's going
25 to be reflected either on the death certificate

1 or in the autopsy report, investigation report,
2 or all of the above.

3 Q. And there would be other information
4 that would be relevant to making that clinical
5 determination that an individual was addicted to
6 a substance during his or her lifetime; is that
7 right?

8 A. What other --

9 Q. Well, for instance, you would want
10 to know some background on the particular
11 person. You would want to have all of that
12 person's medical records, right?

13 MS. HERMIZ: Objection to form.

14 A. Obtaining a decedent's medical
15 records is not a panacea for elucidating the
16 chronicity of their drug -- potential drug
17 abuse. Primary care doctor records might not
18 reflect a history of drug abuse. They might,
19 but they might not, so --

20 Q. They might or they might not?

21 A. Yeah. So I'm not really sure what
22 you're -- where you're going, what you're trying
23 to ask of me to answer yes or no to here.

24 MS. RANJAN: Sorry, Anne. Were you
25 saying that you wanted to take a break?

1 MS. KEARSE: I thought you were
2 still -- are you done?

3 MS. RANJAN: Oh, no. I'm not.
4 Yeah. I just -- sorry. I overheard.

5 Q. So you've testified that you do not
6 make clinical diagnoses?

7 A. That's correct.

8 Q. And so with respect to box 33 on the
9 death certificates that you previously referred
10 to --

11 A. 33F is --

12 Q. It's 33F. Thank you.

13 A. Yes.

14 Q. That's not a determination of
15 clinical chronic drug use, true?

16 A. Clinical chronic drug use?

17 Q. It's not a clinical determination,
18 correct?

19 A. It's -- that's a post-mortem --
20 that's a general -- the statement of chronic
21 drug abuse or acute and chronic drug abuse with
22 the chronic part indicating prior drug abuse is
23 a classification that could be drawn --
24 supported by prior clinical documentation,
25 though obviously I'm not making a clinical

1 assessment because the person is dead. It can
2 also be, in part, supported by history from
3 non-clinical sources, such as friends and
4 family; though I'm not directly talking to the
5 decedent, we're getting that history because the
6 decedent is dead. And it can be information
7 drawn upon by anatomic findings that are
8 consistent with or indicative of prior drug
9 abuse, for example, needle track scars on the
10 arms or evidence of -- of organ changes
11 associated with substance abuse, such as liver
12 disease with alcoholism or heart disease
13 associated with alcohol abuse or cocaine abuse
14 or methamphetamine abuse.

15 Q. And so in order to determine whether
16 or not a particular person was addicted during
17 his or her lifetime, we would need to go back
18 and review all of that information with respect
19 to that individual case, correct?

20 A. Yes.

21 Q. And we can't make that kind of a
22 determination based on statistics; is that
23 right?

24 A. You mean death certificate --
25 death -- death statistics, as listed in -- in

1 the end of your reports?

2 Q. No. I'm asking we can't make that
3 kind of a determination based on statistics,
4 like, for instance, the information that's found
5 in Exhibit 2?

6 MS. HERMIZ: Objection to form.

7 Q. Can you look through Exhibit 2 and
8 tell me which of those individuals was addicted
9 to a substance during his or her lifetime?

10 A. The vast majority of these
11 individuals, as I'm just glancing down this list
12 with methamphetamine and fentanyl toxicity,
13 fentanyl toxicity, acute mixed drug toxicity
14 where there's fentanyl and cocaine included,
15 fentanyl and methamphetamine included -- the
16 vast majority of these people are chronic drug
17 addicts because, generally speaking, people do
18 not choose to start their -- their substance
19 abuse with a heavy-duty street drug. So the
20 vast majority of these people, as we're glancing
21 down this list, are probably chronic drug
22 abusers. Even people that abuse what is
23 prescription medication, it's the rare
24 individual that's unfortunate enough to fatally
25 overdose the first time they take a dosage

1 abusively or they take more than what's
2 prescribed to them. These individuals usually
3 build up to larger levels over a period of time.

4 So the vast majority of -- of the
5 people that are accidental drug overdoses that
6 come to the coroner or the medical examiner's
7 office are people that have an issue with
8 chronic drug abuse and are dying from an
9 acute -- so you can say they have a chronic
10 disease or chronic drug abuse and they're dying
11 from an acute exacerbation of their disease.

12 There might be one or -- you know,
13 the rare individual that just took too -- you
14 know -- you know, indeed was a first-time user,
15 and then you could argue, well, they're not a
16 chronic drug abuser, this is the very first time
17 they've ever abused drugs, and, therefore,
18 they're not a chronic abuser. But for the
19 individuals that are on this list, almost all of
20 these people are going to be chronic drug
21 abusers with an acute exacerbation of their
22 chronic drug abuse disease that's bringing about
23 their death.

24 I mean, that's like looking at
25 someone who's like a chronic alcoholic dying of

1 an acute alcohol poisoning versus like a college
2 student who is joining a frat and chugs a bottle
3 of vodka. You know, they're both dying from the
4 same alcohol poisoning, but they're -- we
5 conceptualize them a little bit differently in
6 terms of their -- of their alcohol poisoning.
7 The chronic alcoholic is viewed by convention as
8 an acute exacerbation of their chronic disease
9 whereas -- and, you know, they can be classified
10 as, you know, acute alcoholism, acute chronic
11 alcoholism, whereas the college student who's
12 not an alcoholic, who's not alcohol tolerant,
13 who chugs the whole bottle of vodka, is then
14 dying of an acute alcohol poisoning that's
15 unrelated to chronic alcoholism.

16 Q. All right. You're now testifying
17 about statistics and I thought that your
18 testimony earlier was that you don't really have
19 any input into the statistics of the office, so
20 I'm a little puzzled by that.

21 MS. HERMIZ: Objection to form.

22 A. I don't generate the statistics, end
23 of year statistics.

24 Q. But since we can tell --

25 A. But I was talking about death

1 certification.

2 Q. Okay. You're talking about Exhibit
3 2?

4 A. Yeah.

5 Q. Okay. So since we can tell from
6 Exhibit 2 who had an addiction, let's look at
7 them. Let's see.

8 MS. HERMIZ: Objection to form.

9 Q. So let's take a look at the very
10 first case on the list, case number 55236.

11 Can you tell me if that particular
12 decedent was addicted to a substance during his
13 or her lifetime?

14 A. This person, 55236, case 55236, is
15 an individual whose death is certified as
16 combined methamphetamine and fentanyl toxicity.

17 Q. So was that person addicted to
18 methamphetamine during his lifetime?

19 A. There's probability that this is not
20 their -- their first -- that their fatal drug
21 toxicity was not their first illicit drug
22 intoxication. It's what one -- it's -- it's
23 very likely what they were addicted to
24 throughout the course of their life -- I can't
25 tell by looking at just the information on

1 Exhibit 2 --

2 Q. Um-hum. And --

3 A. -- and I would be guarded with
4 saying that -- with certainty they were probably
5 a drug -- had chronicity of drug abuse without
6 referring back to the specific case.

7 Q. Right. So in order to make that
8 determination, you would need to go back and
9 refer to the specific case?

10 A. Yeah, just review the specific case
11 and then -- and see if the investigation
12 supported acute chronic active drug abuse.

13 Q. All right. Let's look at the second
14 one, case number 55235. Was that person
15 addicted to fentanyl during her lifetime?

16 A. Well, people who abuse opiate-type
17 drugs generally will -- might abuse various
18 opioid drugs throughout the course of their
19 disease process, so I can't tell by their
20 terminal intoxication what their pattern of
21 usage previously was for various drugs. They
22 might have been using fentanyl in the past.
23 They might have been using other opioid drugs in
24 the past and I can't even say with certainty
25 that they are a chronic -- issue of chronic drug

1 abuse unless there is -- one goes back and looks
2 at the specific case.

3 Q. And the same would be true of --

4 A. Of all of these, every case, every
5 case.

6 Q. Right. You can't tell me, sitting
7 here, which of these cases involved someone who
8 was addicted to a substance during his or her
9 lifetime?

10 A. Yeah. If we went back and looked at
11 the specific cases, I think we would find that
12 the vast -- virtually all of these deaths are in
13 individuals with evidence of chronic -- acute
14 chronic active drug abuse.

15 Q. That wasn't my question, Doctor,
16 with all due respect. My question was, you
17 can't tell me, sitting here today, which one of
18 these individuals was addicted to a substance
19 during his or her lifetime?

20 A. Right. You keep asking me about
21 addiction and who's addicted, and that's, I
22 feel, like a clinical classification, and as a
23 pathologist, the terminology that I use is
24 chronic drug abuse; and so I can talk in terms
25 of who has a chronicity of drug use, and then

1 the vast majority of the people on this list I
2 think we would find have a history of chronic,
3 active drug abuse, which might mean they have a
4 clinical documentation of addiction, but then
5 again, they might not have -- they might not
6 have any documented clinical histories. They
7 don't go to doctors, or they might go to a
8 doctor and their doctor never diagnosed them
9 with addiction in their past. So the lack of a
10 clinical diagnosis of addiction doesn't mean
11 that any specific decedent didn't have -- wasn't
12 an addict prior to their death, but as a
13 pathologist certifying their death, I can
14 reflect chronicity of drug abuse as chronic
15 active drug abuse.

16 Q. Okay. I'm going to ask my question
17 one more time because I still am just not sure
18 I've gotten an answer. I don't believe I have.
19 The question that I asked you was, you can't
20 tell me, sitting here today, which of these
21 specific cases involved an individual who was
22 addicted to a substance during his or her
23 lifetime? Not generalities, not anecdotal. Can
24 you tell me whether case number 55235, whether
25 that person was addicted to a substance during

1 their lifetime based on the information here?

2 MS. HERMIZ: Objection to form.

3 A. I -- virtually all of the people on
4 this list --

5 Q. I'm not talking about all the people
6 on this list, Doctor. I'm talking about case
7 number 55235. Was she addicted to a substance
8 during her lifetime, yes or no?

9 A. I think the only way I can answer
10 that question is that based upon the information
11 on this list, I can't say with certainty that
12 that specific individual has a documentation
13 of -- of chronic drug abuse by death
14 investigation or prior clinical documentation of
15 addiction within medical records that might or
16 might not exist.

17 Q. So the answer to my question is no,
18 you can't tell me?

19 A. Like I just said, I can't say based
20 upon -- for any specific individual on this
21 list. I believe the vast majority, if not all
22 of the people on this list, have -- what we
23 would find, have a history of chronic drug
24 abuse.

25 FURTHER EXAMINATION OF GEORGE STERBENZ, M.D.

1 BY MR. CHEFFO:

2 Q. Let me see if we -- I think we -- I
3 think I understand you, but chronic drug abuse
4 is not necessarily addiction; you would agree
5 with me, right?

6 A. Well, from my personal point of
7 view, I believe the term "addiction" is used in
8 the clinical setting and chronic drug abuse is
9 used in a pathologic setting in forensic
10 pathology.

11 Q. You are not qualified to make a
12 diagnosis of a living human being as to whether
13 they're addicted pursuant to the DM-4 {sic}, the
14 DSM-5 or any other diagnostic tool; isn't that
15 right?

16 A. Addiction, according to those
17 standards, implies psychological and physical
18 dependence on a drug, so I cannot make those
19 assessments in a decedent. It's not only do I
20 not do it on living people, but on decedents it
21 cannot be done because they're dead and that's
22 an assessment that's made on living people.

23 Q. Understood. It can't be done on
24 dead people because they're dead and you cannot,
25 because you are not qualified, make a

1 determination about whether someone was addicted
2 while they were alive; isn't that fair?

3 A. I don't -- you can't apply
4 diagnostic criteria that -- that can only be
5 applied to living people on dead people
6 directly.

7 Q. I think -- I think we're actually
8 agreeing here, Doctor.

9 A. You keep saying -- you're asking --
10 I can't do it because I don't know how to do it.
11 I probably could learn how to do it, but you
12 can't apply criteria for living people on dead
13 people because those criteria no longer apply.
14 Those are psychological and physiologic criteria
15 and I have pathologic criteria that I'm --

16 Q. And I'm trying to -- I think we're
17 agreeing, okay, that you can make a
18 determination based on looking at a decedent
19 that they may or may not be -- based on the
20 information that's available to you, they may or
21 may not have been a chronic drug abuser in your
22 estimation, right; that's something that you do
23 from a pathological perspective?

24 A. Routinely on the death certificates
25 and in the autopsy reports I will make a

1 determination or a classification of chronic
2 drug abuse or chronic active drug abuse.
3 Realistically, those chronic drug abusers are
4 people that had addiction during life.

5 Q. But how do you know that? You don't
6 even know the criteria. What are the criteria
7 for addiction? You've told us that you're
8 wedded to the scientific definition. Tell us,
9 then, on the record what is the definition of
10 addiction.

11 A. People with clinical -- I mean, a
12 clinical diagnosis of addiction follows criteria
13 for psychological dependence and physiological
14 dependence.

15 Q. What are they? Do you hold yourself
16 out in diagnosing living human beings with
17 addiction? Have you ever done that?

18 MS. HERMIZ: Objection.

19 A. No, and I'm not presenting myself as
20 such at this time.

21 Q. Okay. So what --

22 A. But it's unrealistic, I mean, to --
23 well, it's unrealistic to suggest that these
24 individuals that are -- have evidence of chronic
25 drug abuse are not -- therefore, did not --

1 would not have fit the criteria for being a
2 person with addiction during life.

3 Q. But that's speculative, right, they
4 may have or they may not have? Someone may have
5 chosen to use a medicine or a drug and not be
6 addicted, right? That's possible, isn't it?

7 A. If a person drinks themselves to the
8 point where they have cirrhosis and alcoholic
9 cardiomyopathy, that person had realistically an
10 addiction to alcohol.

11 Q. How do you know that? How do you
12 know that they fit the characteristic of
13 addiction if you don't even know what addiction
14 is?

15 MS. HERMIZ: Objection to form.

16 A. Well, in some instances -- because
17 some of the criteria for drug withdrawal is a
18 physiologic process, and I can't see after
19 death, and maybe we can elicit that kind of
20 history that an individual suffered with
21 physiological drug withdrawal, whether it be
22 alcohol or opiates, and then there is evidence
23 there of that individual having addiction
24 clinically. In many instances such clinical
25 documentation simply doesn't exist.

1 Q. Are you -- are you qualified to make
2 a clinical diagnosis of addiction in a living
3 human being? Have you done that in the last 30
4 years?

5 A. No, and I'm not doing that.

6 Q. So you certainly, then, wouldn't be
7 qualified to look back after somebody dies and
8 determine if they're addicted if you're not
9 qualified to basically suggest that they're
10 addicted when they're alive? Isn't that kind of
11 an illogical --

12 MS. HERMIZ: Objection to form.

13 A. That's ridiculous.

14 Q. So you think you could make --

15 A. Realistically --

16 Q. Excuse me. I'm not done with my
17 question. You could make determinations after
18 the fact on dead people about whether they were
19 addicted even though you have never in your
20 life, at least in the last 30 years, made a
21 determination of whether a live person is
22 addicted? Is that really your testimony?

23 MS. HERMIZ: Objection to form.

24 A. It is my testimony that
25 realistically the -- a large percentage, if not

1 the majority of the individuals that are dying
2 with -- on Exhibit 2, with their varied illicit
3 drug toxicities realistically had -- were
4 struggling with drug addiction during their
5 life, thus the classification of chronic drug
6 abuse.

7 Q. Will we find -- if we look at all of
8 your reports from 2016, will we find a
9 determination that you've made a medical
10 determination with a reasonable degree of
11 scientific certainty, medical certainty, that an
12 individual was addicted? Will we find that?

13 A. No, and that's not what I said I do.

14 Q. Okay. So you've never actually
15 determined in an actual medical record or report
16 or autopsy report that somebody was addicted,
17 correct?

18 A. I don't --

19 Q. Yes or no?

20 A. I don't make a clinical
21 determination of addiction in a decedent.

22 Q. Okay. So the answer is no, you have
23 never made a determination and never written in
24 an autopsy report or any record in connection
25 with your work that a decedent was addicted,

1 right, because that's not what you're supposed
2 to do, correct?

3 MS. HERMIZ: Objection to form.

4 Q. That's really a yes or no question.

5 A. Well -- so -- once again, I make a
6 determination of chronic and acute drug abuse or
7 chronic active drug abuse that is a pathologic
8 correlate to a clinical manifestation of
9 addiction. So I am not making a clinical
10 diagnosis of addiction, but it implies a
11 clinical -- that individual had clinical
12 addiction. Just like when I make a diagnosis of
13 a dilated cardiomyopathy due to chronic
14 ischemia, I can't say -- I can't make a
15 diagnosis necessarily of clinical congestive
16 heart failure because that's a diagnosis that's
17 made during life, but I can state to a
18 reasonable degree of certainty that that person
19 had -- had to have had congestive heart failure
20 during life.

21 Q. Can we agree, then, that the --
22 while you're going to make -- you have made a
23 finding of chronic drug abuse or acute drug
24 abuse, that may be evidence of addiction or may
25 be used in connection with some other

1 information or diagnosis, but you're not the
2 person and your office is not the entity to be
3 making determinations about somebody was
4 addicted during their life?

5 A. Once again --

6 Q. Do you need the question read back
7 because you can keep answering another question
8 if you want. I'll keep asking my question.

9 A. -- the finding of -- that an
10 individual is dying with chronic active drug
11 abuse is a pathologic implication that that is a
12 person that was dealing with addiction during
13 their life.

14 Q. And if someone asked you would you
15 swear under oath that any of these people --
16 frankly, anybody that you have seen in the last
17 18 years was or was not addicted, would you be
18 in a position to make that determination and
19 sign your name to it?

20 MS. HERMIZ: Objection to form.
21 Counsel, we're about 20 minutes
22 over, so --

23 THE VIDEOGRAPHER: 20 minutes left.

24 MR. CHEFFO: We may need to go 20
25 minutes over if I can't get an answer.

1 Q. Do you want me to read it back,
2 Doctor?

3 A. Yeah. Friends and family and
4 primary care doctors certainly -- well, friends
5 and family will -- it is not unusual for friends
6 and family of decedents to state that an
7 individual with evidence of chronic drug abuse
8 had no history of drug abuse or had no history
9 of addiction, but their -- nonetheless that
10 individual might have physical stigmata of
11 chronic drug abuse and an acute drug
12 intoxication that's fatal that's bringing them
13 to the office that supports that they were
14 indeed someone who suffered with a history of
15 drug addiction and drug use.

16 Q. Do you remember my question? Do you
17 remember the question I asked you?

18 A. Yeah. You were asking me that --
19 you were making a statement that I am not
20 qualified to render an opinion that decedents
21 for which I have conducted death investigations
22 might have been drug addicts during their life.

23 Q. That's not the question I asked you.
24 Let's just see if we can do this in bite size so
25 we can actually end this deposition, if that

1 would be convenient for you and us.

2 You have never made a determination
3 that any single decedent that you have ever
4 performed their autopsy or looked at their case
5 was addicted during their lifetime; fact?

6 A. I've never classified any decedent
7 with the term "addict."

8 Q. And you've never said someone had
9 addiction disorder during the course of their
10 lifetime, correct?

11 A. Correct.

12 Q. You've never said someone was an
13 opioid addict during their lifetime, correct?

14 A. No, that's not correct.

15 The classification of chronic active
16 alcoholism indeed implies that -- or chronic
17 active drug abuse or chronic opioid drug abuse
18 or whatever implies that they are chronically
19 using -- they're -- or abusing drugs. Abuse
20 is -- the classification of abuse is, in and of
21 itself, an implication of addiction.

22 Q. Is abuse addiction clinically? Is
23 abuse -- if someone said you are a drug abuser,
24 is it your testimony under oath that that would
25 mean that there would be a clinical diagnosis of

1 addiction without knowing anything more?

2 A. Chronicity of abuse --

3 Q. I don't know what that means. What
4 does chronicity mean, Doctor?

5 A. Well, let me finish my statement.
6 Chronicity of abuse is part of the diagnosis
7 of -- of -- you know, considered in part of the
8 diagnosis of addiction, so -- what was your
9 question again?

10 Q. You've told us five times now,
11 right, that you don't know the definition or the
12 criteria for addiction, right? Just like, you
13 know, I am not holding myself out as a forensic
14 pathologist, presumably you don't hold yourself
15 out as a psychiatrist or an addiction
16 specialist, correct? Is that true?

17 A. I am not presenting myself as a
18 clinical addiction or a clinical substance abuse
19 patient management healthcare provider.

20 Q. And if a live person came to you and
21 said, "Doc, do I have an addiction disorder,"
22 would you tell them, "If you're concerned about
23 that, I think you should talk to a healthcare
24 provider who actually specializes in that," and
25 maybe you might refer them or say, "Go talk to

1 your primary care," or would you say, "Come on
2 and sit down and I'll give you a diagnosis"?

3 A. I would not -- yes, I would refer
4 them back to their primary care doctor or an
5 appropriate clinical specialist.

6 Q. And that's because the diagnosis of
7 addiction is complicated and it would require
8 someone to understand all the parameters, what
9 the factors were, be able to take a history,
10 someone who was qualified and specializes in
11 that area, right?

12 A. That's because I'm a forensic
13 pathologist. Obviously if someone came to me
14 and said, "I have high blood pressure," I would
15 refer them back to their primary care doctor.

16 Q. Agreed. And just like determining
17 whether someone has addiction disorder when
18 they're alive, it's just as complicated, if not
19 more complicated, to determine whether they were
20 addicted after they're dead because you don't
21 even have a chance to talk to them and ask them
22 any questions, right?

23 MS. HERMIZ: Objection.

24 A. You're missing the whole point.

25 Q. I don't think so, Doctor.

1 A. I think you are. I think you are.
2 I think you're not hearing what I'm saying
3 because I'm not saying what you want me to say,
4 but I am saying that the vast majority of these
5 people on Exhibit 2 are indeed -- if we looked
6 at the individual cases, have issues of chronic
7 drug abuse or acute exacerbations of their
8 chronic drug abuse, and are -- fit the -- had a
9 probable history of addiction leading up to
10 their death. It's very, very extraordinary for
11 someone to, just out of the blue, take fentanyl
12 and methamphetamine together and happen to die,
13 and it's very, very extraordinary for someone to
14 just, you know, mix some fentanyl and meth --
15 and methadone and oxycodone together and die in
16 one -- in a one-time shot.

17 Q. So tell me --

18 A. These are much more likely people
19 that have a history of chronicity, which is part
20 of the spectrum of their addiction. Even the
21 people -- this guy over here, 55370, with
22 methadone, methadone, this person could be in a
23 drug addiction treatment program and then
24 concurrently abused oxycodone and fentanyl.

25 Q. Don't you think it's a little

1 interesting when I asked you specific questions
2 about any of these, you had no recollection, now
3 you have specific understandings about how these
4 people used their drugs?

5 MS. HERMIZ: Objection to form.

6 Q. Which one of these did you work on?
7 Let's get back to the methadone -- the
8 methamphetamine. You couldn't tell me any
9 answers about any of these people, right, so you
10 don't really know anything about these cases, do
11 you?

12 MS. HERMIZ: Objection to form.

13 Q. Do you?

14 A. I don't even know what your question
15 is.

16 Q. Let's just -- I want to talk
17 specifics because you keep pointing randomly to
18 people. Tell me, then, details about -- you've
19 made a broad statement that you think many of
20 these people or most of them are drug abusers
21 and that's evidence of addiction or something
22 along those lines.

23 So let's talk about the very first
24 one. Tell me about this person's use, the
25 frequency, and your basis for a determination

1 that you believe they had an addiction disorder
2 while they were alive.

3 MS. HERMIZ: Asked and answered.

4 Q. Can you do that?

5 A. I've answered that already.

6 Q. Can you?

7 A. I feel like I'm just answering the
8 same question over and over again.

9 Q. Can you do that for any of these
10 specific people?

11 A. I've answered it in so many
12 different ways, I don't even know how to answer
13 it anymore.

14 Q. Yes or no, can you do it for any of
15 these specific people? We can go through and do
16 a checkmark.

17 A. I think for each of these specific
18 people, we could go back and look and see that
19 the majority of these individuals had evidence
20 of chronicity in their history.

21 Q. Let's take the first one, Doctor.
22 When is the first time that this person used an
23 illicit substance?

24 A. I obviously cannot determine that by
25 the information here.

1 Q. How often did they use it?

2 A. I obviously can't determine that by
3 this -- the information here.

4 Q. Did they have drug-seeking behavior?

5 MS. HERMIZ: Objection to form.

6 A. Well, they -- they sought out
7 methamphetamine and toxicity -- methamphetamine
8 and fentanyl, along with -- well, so that is --
9 those were illicit drugs that they sought out.

10 Q. Is it your testimony that you're
11 certain to a reasonable degree of medical
12 certainty that this wasn't the first time that
13 someone used all these medicines or these drugs?

14 A. I'm saying that any individual on
15 this list is -- one cannot reach a degree of
16 certainty based upon the information on this
17 list individually for individuals, but if we
18 were to go back and look at the individual
19 cases, the vast majority of these individuals
20 realistically are going to have a history of
21 chronic drug abuse with an acute exacerbation.

22 Q. So if the vast majority -- you keep
23 testifying that the vast majority, so then it
24 should be easy to tell us all the ones if the --

25 A. That's not what I'm saying. You're

1 just misrepresenting what I'm --

2 Q. It's your testimony.

3 A. No, it's not.

4 Q. So is your testimony that you
5 believe that there are individuals here who may
6 or were likely addicted but you cannot identify
7 one specific --

8 A. My testimony is what I said it was.

9 Q. Well, I don't seem to be able to
10 understand it.

11 A. The vast -- I believe that if we
12 looked at the individual cases beyond the
13 information that's provided on this list, the
14 vast majority are probably individuals with
15 chronic drug abuse histories and are dying with
16 an acute exacerbation of their -- of their drug
17 use.

18 Q. And if you wanted to validate that
19 hypothesis --

20 A. For example --

21 Q. -- what would you do for all of
22 these? What would you want to do? If you
23 wanted to show the vast majority, let's say 80
24 percent of these people, 75 percent, tell me the
25 specific steps that you would need to validate

1 that hypothesis.

2 A. I would start just by reviewing the
3 death certificates first.

4 Q. Well, the death certificates are
5 only based on the information in the file,
6 right? So that's the first thing you would do.
7 What else would you do?

8 A. I would review -- you could start
9 with reviewing what's public record, the autopsy
10 report, the investigation report and the death
11 certificate.

12 Q. And that would tell us whether
13 somebody was addicted during life?

14 A. That would tell us -- that would
15 tell us if they have a history of chronic drug
16 abuse by investigation.

17 Q. And would that tell us -- I'm
18 talking about whether they were addicted.
19 That's what I keep asking. You keep talking
20 about chronic drug abuse. Because again,
21 Doctor, I'm using your words. Your point is if
22 you said -- you're conflating chronic drug
23 abuse, right, but then you said the vast
24 majority of these people would be addicted,
25 okay, and I'm trying to find out since -- you

1 can't understand that from looking at your death
2 certificate.

3 A. The vast majority of these people I
4 think we would find have a history of chronic
5 drug abuse.

6 Q. Okay.

7 A. The vast majority of people with
8 chronic drug abuse have a history of -- or --
9 either have a history of addiction or were
10 addicted, and that's why they have their
11 history -- their pattern of chronic drug abuse.

12 Q. What's your scientific,
13 peer-reviewed data or epi studies that you're
14 relying on to say that the vast majority of
15 these people who would suffer from chronic drug
16 abuse were addicted? Is it just total
17 speculation?

18 MS. HERMIZ: Objection to form.

19 A. No. The vast majority of people
20 with chronic substance abuse, particularly
21 illicit street drugs, are struggling with
22 addiction.

23 Q. Okay. What's your data for that?

24 A. It's a fact.

25 Q. Okay. If it's a fact, then you

1 should be able to justify it.

2 A. It's true. It's just a fact.

3 Q. It's true because you say so?

4 MS. HERMIZ: Objection to form.

5 A. It's true because it's true.

6 Q. So you don't know? You don't have
7 any data, do you?

8 A. The -- the classification of chronic
9 drug abuse is a -- is the pathologic correlate
10 of a clinical diagnosis or the clinical
11 manifestation of addiction, just like the
12 pathologic diagnosis of -- of ischemic
13 cardiomyopathy is an anatomic manifestation of
14 clinical congestive heart failure.

15 Q. I think we've been through this, but
16 you've told me they're not the same and you
17 don't know what addiction is and --

18 A. The terminology is not the same, but
19 one is implying the other.

20 Q. So is it your testimony that if we
21 see in an autopsy report that someone has
22 chronic drug abuse, that someone would
23 automatically determine that that person had an
24 addiction disorder during their lifetime? Is
25 that really your testimony?

1 A. Some of the individuals that are --
2 that have autopsy or post-mortem classifications
3 of chronic active drug abuse will have clinical
4 documentation of drug abuse or addiction abuse
5 or addiction disorder during their life. Some
6 won't.

7 Q. But they're not automatically --
8 whether documented or not, they're not
9 automatically addicted or they would be
10 diagnosed with addiction disorder?

11 A. They would have to be evaluated for
12 addiction disorder to start with to get that --
13 such a classification.

14 Q. And you wouldn't be the person to do
15 that, would you?

16 A. Well, I'm doing -- I'm doing a
17 post-mortem examination. I'm not doing a
18 clinical assessment. So I can't -- I'm not
19 going to end up making a diagnosis of addiction
20 disorder. They're dead. So the whole purpose
21 of that type of classification is for prognosis
22 and treatment. They're dead. I'm going to give
23 them a post -- an appropriate pathologic
24 classification, but some of those individuals
25 that I will be performing death investigations

1 on, they're dying with drug toxicities and
2 history of chronic drug overdose, will have had
3 clinical assessments during their life and will
4 have had documentation of -- of addiction
5 disorder during their life. And I know that
6 some of the individuals that I perform autopsies
7 on have, but some have never had, that type of
8 clinical intervention so they will never have
9 that clinical diagnosis of addiction disorder.
10 But that doesn't negate their post-mortem
11 pathologic finding. You just don't throw it out
12 the window because you don't have a -- you
13 weren't lucky enough to get a clinical diagnosis
14 of addiction during life. The pathologic
15 diagnosis still holds and that still does imply
16 that they had an addiction during life, just
17 like an individual that might not have a
18 diagnosis of heart disease during life and then
19 they die and I do an autopsy and I find heart
20 disease. That doesn't mean they didn't have it.
21 It means it wasn't diagnosed during their life.

22 Q. I think you've said that probably
23 ten times already, and I'm going to keep asking
24 my questions and I'm going to ask for more time,
25 but you keep saying the same thing and you're

1 filibustering.

2 A. I am not filibustering and I've
3 answered your question many times --

4 Q. You have not.

5 A. -- and I'm just not saying what you
6 want.

7 Q. That's not true, Doctor.

8 A. So you keep asking the same question
9 over again.

10 Q. Are you done, because you tell me
11 when you're done and I'm going to ask another
12 question?

13 Can you make a diagnosis to a
14 reasonable degree of medical certainty that any
15 one of the people on this list from 2016 who had
16 drug abuse to a reasonable degree of medical
17 certainty was addicted to any substance? Can
18 you do that?

19 A. I can't answer that question
20 anymore. I feel like I've -- it's been asked,
21 I've answered. I've answered in as many ways as
22 I can. I have nothing left to say.

23 Q. Doctor, you've told me it implies
24 it, okay. You've said that a number of times.
25 And my question is specific. It's, can you make

1 a determination to a reasonable degree of
2 medical certainty, based on a finding in an
3 autopsy report or some other finding that
4 someone had chronic drug abuse, that you were
5 willing to determine that that person had an
6 addiction disorder?

7 MS. HERMIZ: Are you talking a
8 pathological diagnosis or a clinical diagnosis?
9 I don't know if that would make a difference.

10 MR. CHEFFO: Well, maybe -- if you
11 don't understand, I'm happy to try and explain
12 it. What I'm trying to understand -- and if you
13 keep saying it, then this should be easy and
14 I'll tell you if I'm missing it. We understand
15 from pathological, he said a number of times --

16 Q. Doctor, I'll talk to you. You said
17 that you could make a determination from a
18 pathological perspective that someone is a
19 chronic drug abuser based on various forms,
20 finding drugs, needle marks, and probably a host
21 of other things, right? That's something that
22 you do as part of your autopsy process, right?
23 Yes?

24 A. Yes.

25 Q. And that's a determination based on

1 looking at somebody when they are deceased,
2 right?

3 A. Obviously. It's a death
4 investigation. The individual is deceased.

5 Q. Right. And that information may
6 inform or be relevant to a determination of
7 whether someone had an addiction disorder when
8 they were alive, agreed?

9 A. Some of that information might be
10 the only information that we have regarding
11 their addiction disorder while they're alive. I
12 mean, some people -- some of these people on
13 this list will obviously have clinical history
14 of -- of a -- clinical documentation of
15 substance abuse, of addiction disorder. Some of
16 them won't have primary care doctors and they
17 won't have clinical documentation of addiction
18 disorder.

19 Q. Let's try and take it in bite size,
20 okay, because -- let's just try and take it in
21 bite size. You need to answer my questions.

22 The mere fact that someone has been
23 found to be a chronic drug abuser as part of an
24 autopsy and medical examiner's finding does not,
25 in and of itself, mean that that person was or

1 was not addicted, right?

2 A. So when you say -- you've just said
3 that a chronic drug abuser can be a chronic drug
4 abuser but doesn't have addiction, meaning a
5 psychological dependence on the drug and/or a
6 physiologic dependence on the drug that
7 they're -- or the substances that they're
8 abusing.

9 Q. Are you asking me a question or --

10 A. I'm trying to clarify your
11 question --

12 Q. My question was --

13 A. -- because I don't think you know
14 what you're talking about when you keep throwing
15 around this term "addiction, addiction," and
16 someone is a chronic abuser, but they're not
17 really addicted, they're just using chronically
18 because they could stop anytime they wanted.

19 Q. I think I've asked you a few times
20 to tell us what the definition of addiction is,
21 and you can't tell us, right?

22 A. Addiction is a psychological and a
23 physical dependence on a substance.

24 Q. Is that the definition in the DSM-5?

25 A. I can't provide testimony about the

1 DSM-5 because I don't work within the scope of
2 the DSM-5.

3 Q. You don't diagnose -- we talked
4 about this. You don't diagnose human beings who
5 are alive with addiction?

6 A. The individuals that I'm
7 investigating are dead.

8 Q. Right. And you do not --

9 A. The DSM-5 is criteria for living
10 people.

11 Q. And that's what we're talking about
12 is extrapolating.

13 A. But if a person is using chronically
14 to the point that they are terminal, they are
15 dying, that they are unlucky enough to die,
16 their chronic drug abuse is a pathologic
17 correlate to an ante-mortem addiction.

18 Q. Is it an automatic? In other words,
19 if you find someone in their post-mortem that
20 they're a chronic drug abuser, is it a certainty
21 and can you say to a reasonable degree of
22 medical certainty that that person was
23 clinically addicted? This is really a yes or
24 no, but you can answer it any way you want,
25 Doctor.

1 A. Some individuals with chronic -- who
2 are -- who there is evidence of chronic drug
3 abuse will have clinical documentation of
4 addiction and some won't. I can't predict which
5 will -- who will and who won't.

6 Q. Move to strike. I'm not talking
7 about whether someone was addicted. That's
8 where you want to keep not answering my
9 question, Doctor. You want to talk about
10 clinical evidence when they were alive, not my
11 question. Okay.

12 My question is, if you make a
13 determination that someone was a chronic drug
14 abuser in a post-mortem, whether they were ever
15 diagnosed or not, is that finding enough --
16 would you then say under oath to a reasonable
17 degree of medical certainty that they are
18 automatically addicted or were addicted during
19 their lifetime? Do they correlate one to one?

20 A. I -- I feel like I've answered the
21 question to my knowledge, and I don't -- at this
22 point I just don't understand what you're asking
23 to answer it in any other way than I already
24 have.

25 Q. Well, again, I think you do, Doctor.

1 Is chronic -- a post-mortem diagnosis of chronic
2 drug abuse, does that mean that someone was
3 clinically addicted full stop when they were
4 alive, or would you need more information to
5 make that clinical diagnosis about whether they
6 were addicted when they were alive?

7 A. Even the determination of chronic
8 drug abuse is based upon more information about
9 when they were alive. So I don't even know what
10 you're talking about at this point. There
11 probably was information about -- many of these
12 individuals that are classified as chronic
13 active substance abusers, they are, they do
14 have -- there is -- that is the clinical or that
15 is the historical information, that they had
16 addiction during their life.

17 Q. If we see someone designated as
18 chronic drug abuser, is it your testimony that
19 it's also your finding that they were addicted
20 when they were alive to a reasonable degree of
21 medical certainty?

22 A. It could be.

23 Q. Is it?

24 A. It could be.

25 Q. Is it, yes or no?

1 A. I don't know. I don't know. On
2 who? What specific person?

3 Q. Anybody.

4 A. Well, I don't know. I can talk
5 about specific people or I can talk in terms of
6 generalities. You're asking in terms of
7 generalities. I can answer in terms of
8 generalities.

9 Q. With respect to any specific person
10 that's diagnosed with a chronic drug abuse
11 problem, does it automatically mean that they
12 were addicted clinically at the time that they
13 were alive?

14 A. That might be how they got their
15 classification of chronic drug abuse to start
16 with.

17 Q. Is it automatic? Can we make that
18 determination just by a finding of chronic drug
19 abuse? Can we?

20 A. As I said, I don't even know how to
21 answer your question anymore. I don't know if
22 there is such a thing as a -- of a -- some -- a
23 non-chronic drug abuser, a non-addict chronic
24 drug abuser. But you're asking apples and
25 oranges to some extent. The terms are related

1 when it's a clinical term. When it's a
2 pathologic term, the classification of chronic
3 drug abuse does indeed imply that there was an
4 addiction during life. There might be a
5 diagnosis of -- a clinical diagnosis of
6 addiction during life, but there might not be a
7 diagnosis of clinical addiction during life. It
8 depends on what type of clinical intervention
9 and interaction that person had during their
10 life. And often I'm using that history of --
11 prior history of a clinical addiction during
12 life to assist me in my certification of the
13 death.

14 Q. In any of your autopsy materials or
15 findings do you ever make a finding that someone
16 was addicted during their lifetime, a direct
17 finding?

18 A. In what autopsy material?

19 Q. Any. Do you ever write that someone
20 was addicted during their life? Have you made
21 that finding?

22 A. I generally refrain from using
23 clinical terminology in a post-mortem state.

24 Q. So the answer is no, you don't
25 determine whether someone was addicted during

1 their life?

2 A. So I don't know, if we go back
3 through every single autopsy report I've ever
4 written, which is in the thousands, if I've ever
5 used the term "addict," but I generally refrain
6 from using clinical terminology or clinical
7 classifications for my pathologic
8 determinations.

9 MR. CHEFFO: Okay. All right. I
10 have no further questions.

11 MS. HERMIZ: Can we take a
12 five-minute break?

13 MR. CHEFFO: Sure.

14 THE VIDEOGRAPHER: Off the record,
15 6:36.

16 (Recess had.)

17 THE VIDEOGRAPHER: We're back on the
18 record, 6:50.

19 EXAMINATION OF GEORGE STERBENZ, M.D.

20 BY MS. HERMIZ:

21 Q. Good evening. We've met before. I
22 just have a couple of questions. I just wanted
23 to clear up a little bit of confusion I had from
24 some earlier questioning today.

25 Do you remember earlier this

1 afternoon counsel for Purdue asked you various
2 questions about some alleged discrepancies in
3 the toxicology results for certain drug overdose
4 cases referenced in Exhibit 2 and Exhibit 3? Do
5 you remember those questions?

6 MR. CHEFFO: Objection.

7 A. Yes.

8 Q. For instance, if you turn to Exhibit
9 3 on page 1 and you look at case number 55724,
10 where the cause of death is carfentanil toxicity
11 and the toxicology results note carfentanil
12 present; is that correct?

13 A. Yes.

14 Q. And then if you turn to Exhibit 2 on
15 page 24, and it's the same case number -- that
16 case number is 55724 -- the cause of death is
17 also carfentanil but in the toxicology results
18 in lists none detected; is that correct?

19 A. Yes.

20 Q. And since counsel originally asked
21 you those questions several hours ago, have you
22 come to any conclusion as to why the toxicology
23 results in Exhibit 2 and Exhibit 3 say different
24 things?

25 A. They say different things because

1 they're different queries. Exhibit 3 queried a
2 urine specimen and Exhibit 2 queried a blood
3 specimen, so for that specific case, 55724, the
4 urine specimen was reported as carfentanil
5 present, although the blood was reported as none
6 detected. So they are two different specimens.

7 Q. And, Doctor, you would agree, based
8 on the specimen tested between the blood and
9 urine, that both of those queries could be
10 accurate; is that correct?

11 MR. CHEFFO: Objection.

12 A. Yes, they both can be accurate.

13 MS. HERMIZ: I have no further
14 questions, Doctor. Thank you for your time.

15 FURTHER EXAMINATION OF GEORGE STERBENZ, M.D.
16 BY MR. CHEFFO:

17 Q. Just a few, Doctor.

18 In Exhibit 2, if you look at page 20
19 of 46, on the top one, 55653 --

20 A. Yes.

21 Q. -- there's -- it's not just blood,
22 this one talks about a urine specimen in Exhibit
23 2, right?

24 A. 55653; is that correct?

25 Q. It's the very first one, yes.

1 A. I only see urine listed.

2 Q. Right. I thought you had testified
3 that Exhibit 2 only tested for blood, or did I
4 get them backwards?

5 MS. HERMIZ: It's a different case
6 number.

7 A. It's a different case number.

8 Q. No. I understand. But there was --
9 there's testing on Exhibit 2 for both blood and
10 urine, right?

11 MS. HERMIZ: Are you talking
12 generally in --

13 MR. CHEFFO: Yes.

14 A. I only see one or the other listed
15 for each individual case.

16 Q. No. I understand. But in Exhibit 2
17 there is testing for carfentanil and it's either
18 blood or urine, but some of them have urine
19 results, some of them have blood results, right?

20 MS. HERMIZ: Objection to form.

21 A. I don't -- I can't tell by looking
22 at this sheet which individuals had urine tested
23 for carfentanil, which -- and which individuals
24 had urine and blood tested for carfentanil, but
25 what I can tell from this query is what's --

1 what was actually queried, and in case number
2 55653 the query was for urine.

3 Q. Am I correct that what you -- your
4 counsel asked you some questions basically to
5 show that one chart had urine testing for some
6 of the decedents and the other had blood
7 testing?

8 MS. HERMIZ: For the one case.

9 A. No. That's not what -- I mean,
10 these are two different queries.

11 Q. I understand.

12 A. So I don't know what the actual
13 toxicology reports are for each of these
14 individuals. But, for example, on Exhibit 2,
15 the very first case, 55236, urine was
16 probably -- had to have been tested. It's just
17 urine wasn't part of the query so you don't
18 have -- it's not reported in this query. It's
19 reporting the blood results in this query.

20 Q. Right. So if we wanted to actually
21 find full, accurate information about these
22 cases, we would actually need the database
23 information that had both blood and urine,
24 right?

25 MS. HERMIZ: Objection.

1 A. You would have to include it in your
2 query.

3 Q. Right. You would have to run a
4 query to actually give us the information so
5 that we could see what the blood testing was and
6 what the urine testing was, right, because in
7 Exhibit 2 and Exhibit 3 some of them show urine,
8 some of them show blood, right?

9 A. For example, all of those presumed
10 discrepancies that you were concerned about
11 earlier were not discrepancies in results,
12 discrepancies in specimens. One was reporting
13 urine and one was reporting blood. Once again,
14 that's apples and oranges. They can be the same
15 but they might be different.

16 Q. Can you run a query to actually
17 provide all of that information, blood and
18 urine, at the same time?

19 A. I don't run the queries so you would
20 have to ask the people that run the queries to
21 set the parameters.

22 Q. When you get information,
23 toxicological information, do you get it
24 typically, blood and urine, at the same time and
25 look at it and then make your findings?

1 A. I don't make final certifications
2 based upon a database query. I have the actual
3 report in hand.

4 Q. What report?

5 A. The toxicology report.

6 Q. So there's a toxicology report?

7 A. Yes.

8 Q. And is that for blood and for urine?

9 MS. HERMIZ: Objection to form.

10 Counsel, I think you're already at
11 two minutes for --

12 MR. CHEFFO: I'm following up just
13 on this question.

14 A. You can talk to the toxicologist
15 about how he proceeds with toxicologic analysis,
16 but in general, the -- you know, during the
17 course of the autopsy I will collect specimens
18 that can be tested toxicologically. Routine
19 specimens that are collected are urine and
20 blood.

21 Urine is a fluid that, you know, we
22 can hold in our body and it can be concentrated,
23 so it doesn't necessarily reflect serum
24 concentrations or blood concentrations, but on
25 the other hand, it might show substances that

1 might not appear in the blood because the levels
2 are too low to be reported. So the screen will
3 often start -- if there is urine to collect,
4 assuming there is -- the individual didn't
5 urinate prior to their death, there is urine to
6 collect, the drug screen will start with a urine
7 screen that's qualitative and then proceed with
8 a blood or serum screen that's quantitative.

9 Q. When you get -- when you get that
10 information, is it in a document, either two
11 separate screens or unified in some way?

12 A. It's in the autopsy report as if you
13 requested an -- you know, an autopsy report
14 through public record, you would get the autopsy
15 report, and the last page is the toxicology.

16 Q. So before you do your final autopsy
17 report, are you presented with a screen of data
18 from a blood tox report and a urine tox report?

19 A. It's all on the same report. Before
20 I do a final certification of an individual who
21 I suspect is dying of a drug overdose, I will
22 make -- you know, have the final toxicology
23 report obviously.

24 Q. And then the last two questions.

25 And all that information you believe

1 is entered into the database and it can be
2 queried as either blood or urine or perhaps
3 both?

4 MS. HERMIZ: Objection to form.

5 A. Yeah. I can't testify as to
6 limitations or what can or cannot be queried
7 for -- within the database, but I just note --
8 these two queries are different and that's
9 why -- there isn't necessarily any discrepancy.
10 It's just that they're different queries.
11 You're looking at -- some of the results are for
12 blood in specific decedents and some are for
13 urine.

14 Q. But they're incomplete, either one
15 of them; they may not be different in what
16 you're saying, but if you looked at Exhibit 2,
17 you wouldn't know the results of Exhibit 3
18 without having Exhibit 3, right?

19 MS. HERMIZ: Objection to form.

20 A. I'm not sure what you're asking.

21 Q. There is certain information there
22 about urine in Exhibit 3 that's not included in
23 Exhibit 2, right? That's what caused us to ask
24 you questions about the potential discrepancy.

25 MS. HERMIZ: Objection to form.

1 A. Both reports are just reporting one
2 specimen, not both, and in some instances one
3 specimen is reported in one of the queries
4 that's not reported, you know, in the other; in
5 some it's the same specimen.

6 Q. Is there different information about
7 the specimens in Exhibit 2 and Exhibit 3?

8 MS. HERMIZ: Objection to form.

9 I think we're over two questions at
10 this point.

11 A. It's not different information.
12 They're just different specimens. I mean, you
13 get different results for -- the results that
14 are reported are based upon the specimen that
15 was queried for.

16 Q. It's not the same in Exhibit 2 and
17 3, you would agree with me?

18 MS. HERMIZ: Objection to form.

19 A. Well, sometimes it's the same.
20 Sometimes a specimen that's within the query is
21 different.

22 Q. Sometimes it's different, sometimes
23 it's the same, right?

24 A. It's your -- it's the query. It's
25 the query that's different.

1 Q. Is the information completely the
2 same or is it sometimes the same, sometimes
3 different?

4 MS. HERMIZ: Objection.

5 This is -- that's the last question.
6 You can answer, Doctor, and then we're done.

7 MR. CHEFFO: These are very simple
8 questions.

9 MS. HERMIZ: You're already over.

10 MR. CHEFFO: Because I'm not getting
11 an answer.

12 MS. HERMIZ: That's not true.

13 A. They're different queries. The
14 information is according to the query.

15 Q. Is the information the same or
16 different?

17 MS. HERMIZ: We're done. You don't
18 need to answer that question. The deposition is
19 over.

20 THE VIDEOGRAPHER: Off the record at
21 6:02.

22 MR. CHEFFO: So we're just going to
23 put on the record that we're reserving our right
24 to keep this deposition open. In my view it's
25 not closed for two or three reasons.

1 The first is the record will show
2 very, very clearly that I believe the witness
3 deliberately delayed on answering questions,
4 sometimes took incredibly long, intentional
5 pauses in order to not answer the question in a
6 timely way.

7 I think the record will also be
8 crystal clear that while I would fully admit
9 that, probably me asking most of them, there
10 were clearly going to be unintelligible and
11 questions that were not clear, I think when the
12 record is read, there were an inordinate number
13 of questions that any person would understand
14 and have answered squarely and candidly and in a
15 timely manner, and as a result, that ate into
16 our legitimate time to take the deposition. So
17 we're going to go back and look at it, and to
18 the extent that we think we need more time, we
19 will request it. I know counsel will probably
20 want to put something -- I suspect that counsel
21 will not agree with that characterization, but I
22 also wanted to just make sure that our point on
23 the record was clear.

24 MS. HERMIZ: And you're correct, we
25 don't agree with the characterization of the

1 witness' testimony. I think Dr. Sterbenz
2 answered all the questions to the best of his
3 ability. He was very precise in answering his
4 questions. And, you know, you were -- you
5 decided which questions you were going to ask
6 him and how long you wanted to go in a certain
7 direction, and that was your decision, and he
8 answered the questions to the best of his
9 ability and he didn't do anything to obstruct
10 the deposition, so we disagree in that respect.

11 MS. KEARSE: And, Mark, I'll just
12 add, you actually did pass the witness and you
13 had other people ask questions and you came back
14 and we let you actually come back and ask
15 questions again after you had passed the
16 witness. So we gave you that courtesy to do
17 that and I don't think that's another reason to
18 keep it open.

19 You also started the deposition
20 talking about all his work in New York City, so,
21 you know, we're here talking about the Akron
22 cases.

23 MR. CHEFFO: I'm not going to argue
24 with you. I don't think there's any prohibition
25 about asking questions that are follow-up within

1 the time period, so, you know, I'm not aware of
2 that rule, and I think to the extent that we're
3 asking about general questions, again, I'm not
4 sure that questions about New York are per se
5 off limits.

6 MS. KEARSE: No. I'm just saying
7 you spent a lot of time on that. We can agree
8 to disagree.

9 MR. CHEFFO: Fair enough.

10

11 (Deposition concluded at 7:05 p.m.)

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1 Whereupon, counsel was requested to give instruction
2 regarding the witness' review of the transcript
3 pursuant to the Civil Rules.

4
5 SIGNATURE:

6 Transcript review was requested pursuant to the
7 applicable Rules of Civil Procedure.

8
9 TRANSCRIPT DELIVERY:

10 Counsel was requested to give instruction regarding
11 delivery date of transcript.

REPORTER'S CERTIFICATE

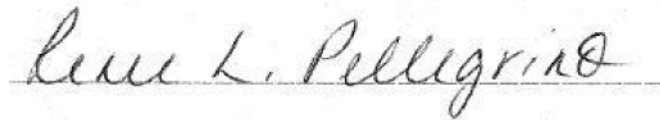
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I, Renee L. Pellegrino, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, GEORGE STERBENZ, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

1 I do further certify that I am not a
2 relative, counsel or attorney for either party, or
3 otherwise interested in the event of this action.

4 IN WITNESS WHEREOF, I have hereunto set my
5 hand and affixed my seal of office at Cleveland,
6 Ohio, on this 22nd day of October, 2018.

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12 Renee L. Pellegrino, Notary Public
13 within and for the State of Ohio

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15 My commission expires October 12, 2020.
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Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

October 22, 2018

To: Motley Rice

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 3058685

Witness: George Sterbenz, M.D. Deposition Date: 10/17/2018

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

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DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3058685
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 10/17/2018
WITNESS' NAME: George Sterbenz, M.D.

In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
my testimony or it has been read to me.

I have made no changes to the testimony
as transcribed by the court reporter.

Date George Sterbenz, M.D.

Sworn to and subscribed before me, a
Notary Public in and for the State and County,
the referenced witness did personally appear
and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn
Statement; and
Their execution of this Statement is of
their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

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DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3058685
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 10/17/2018
WITNESS' NAME: George Sterbenz, M.D.

In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
my testimony or it has been read to me.

I have listed my changes on the attached
Errata Sheet, listing page and line numbers as
well as the reason(s) for the change(s).

I request that these changes be entered
as part of the record of my testimony.

I have executed the Errata Sheet, as well
as this Certificate, and request and authorize
that both be appended to the transcript of my
testimony and be incorporated therein.

Date George Sterbenz, M.D.

Sworn to and subscribed before me, a
Notary Public in and for the State and County,
the referenced witness did personally appear
and acknowledge that:

They have read the transcript;
They have listed all of their corrections
in the appended Errata Sheet;
They signed the foregoing Sworn
Statement; and
Their execution of this Statement is of
their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

ASSIGNMENT NO: 10/17/2018

Date _____ George Sterbenz, M.D.
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20____.

Commission Expiration Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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